S. HRG. 101-749

MEDIGAP INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

FEBRUARY 2, 1990

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
29-982 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S361-36.

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, Jr., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM A. DASCHLE, South Dakota

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
DAVE DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVE SYMMS, Idaho

Vanda B. McMurtry, *Staff Director and Chief Counsel*
Edmund J. Mihalski, *Minority Chief of Staff*

Subcommittee on Medicare and Long-Term Care

JOHN D. ROCKEFELLER IV, West Virginia, *Chairman*

LLOYD BENTSEN, Texas
MAX BAUCUS, Montana
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
TOM DASCHLE, South Dakota

DAVE DURENBERGER, Minnesota
BOB DOLE, Kansas
BOB PACKWOOD, Oregon
JOHN HEINZ, Pennsylvania
JOHN H. CHAFEE, Rhode Island
JOHN C. DANFORTH, Missouri

CONTENTS

OPENING STATEMENTS

Page
Rockefeller, Hon. John D., IV, a U.S. Senator from West Virginia, chairman of the subcommittee 1
Baucus, Hon. Max, a U.S. Senator from Montana 2
Durenberger, Hon. Dave, a U.S. Senator from Minnesota 4
Pryor, Hon. David, a U.S. Senator from Arkansas 5
Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan 7
Daschle, Hon. Tom, a U.S. Senator from South Dakota 8

COMMITTEE PRESS RELEASE

Finance Subcommittee To Hold Hearing on Medigap Insurance 1

ADMINISTRATION WITNESS

Shikles, Janet L., Director, Health Financing and Policy Issues, U.S. General Accounting Office, accompanied by Tom Dowdal, Assistant Director 13

CONGRESSIONAL WITNESSES

Kohl, Hon. Herbert, a U.S. Senator from Wisconsin 9
Wyden, Hon. Ron, a U.S. Representative from Oregon 9

PUBLIC WITNESSES

Pomeroy, Earl R., president, National Association of Insurance Commissioners and Commissioner of Insurance, State of North Dakota, Bismark, ND 25
Rice, Thomas, Ph.D., associate professor, department of health policy and administration, School of Public Health, University of North Carolina, Chapel Hill, NC 27
Jenckes, Linda, vice president, Federal affairs, Health Insurance Association of America, Washington, DC, accompanied by Robert Shapland, vice president, Mutual of Omaha 36
Spielman, Alan P., executive director, government programs legislation, Blue Cross and Blue Shield Association, Washington, DC 39
Shearer, Gail E., manager, policy analysis, Consumers Union, Washington, DC 52
Hurst, Victor, Ph.D., member, board of directors, American Association of Retired Persons, Clemson, SC 54

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Baucus, Hon. Max:
    Opening statement 1
Bentsen, Hon. Lloyd:
    Prepared statement 63
Daschle, Hon. Tom:
    Opening statement 8
Durenberger, Hon. Dave:
    Opening statement 4
Hurst, Victor:
    Testimony 54
    Prepared statement 63
    Information supplied for the record as requested by Senator Riegle 66

Page
Jenckes, Linda:
  Testimony 36
  Prepared statement 68
  Information supplied for the record as requested by Senator Riegle 73
Kohl, Hon. Herbert:
  Testimony 9
Mitchell, Hon. George J.:
  Prepared statement 113
Pomeroy, Earl R.:
  Testimony 25
  Prepared statement 113
  Information supplied for the record as requested by Senator Riegle 115
Pryor, Hon. David:
  Opening statement 5
  Prepared statement 117
Rice, Thomas:
  Testimony 27
  Prepared statement 118
Riegle, Hon. Donald W., Jr.:
  Opening statement 7
Rockefeller, Hon. John D., IV:
  Opening statement 1
  Congressional Research Report on Medigap Insurance 121
Shearer, Gail E.:
  Testimony 52
  Prepared statement 141
  "Beyond Medicare," a reprint from Consumer Reports Magazine 147
Shikles, Janet L.:
  Testimony 13
  Prepared statement with appendix 165
  Responses to questions from Senator Riegle 170
Spielman, Alan P.:
  Testimony 39
  Prepared statement with attachments 171
Wyden, Hon. Ron:
  Testimony 9
  Prepared statement 177

MEDIGAP INSURANCE

FRIDAY, FEBRUARY 2, 1990

U.S. Senate,
Subcommittee on Medicare and Long-Term Care,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:01 a.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Pryor, Riegle, Daschle, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-4, January 23, 1990]

Finance Subcommittee To Hold Hearing on Medigap Insurance

Washington, DC—Senator John D. Rockefeller IV, (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long Term Care, announced Tuesday that the Subcommittee will hold a hearing on issues relating to Medigap insurance policies.

The hearing is scheduled for *Friday, February 2, 1990 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Chairman Rockefeller said, "Seniors understandably are concerned with the large increases in their Medigap insurance premiums this year. Premium hikes have followed both the enactment and repeal of the catastrophic program. This hearing aims to find out why. We also will explore whether the elderly are getting a good buy for the billions of dollars they spend on Medigap insurance."

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. The first witness has not appeared but it is already 2 minutes after 10:00 so we are going to proceed. I want to thank all of those who are here this morning.

I hope that today's hearing sheds some real light on what I consider very troubling increases in seniors' premiums for Medicare supplemental policies, commonly referred to as Medigap policies. I know that a variety of factors will be pointed to, and for example, part of the reason will be related to repeal of the Medicare Catastrophic Act. One thing that is puzzling is that last year's premiums—last year's premiums—on Medigap policies rose substantially and that was following the enactment of the Catastrophic Act.

One survey, conducted last year, found that 1989 Medigap premiums increases ranged from 10 percent all the way up to 133 percent and, again, that was with the Catastrophic law still on the books. This year, premiums once again are on the rise. The GAO has estimated 1990 Medigap premium increases will average at 20 to 30 percent, ranging from about 5 percent up to over 50 percent.

Now, I am puzzled and I am troubled by these rate hikes. Total Medicare costs increased by 10 percent in 1989; and the estimates are that they will be about 10 percent again this year. This is troubling, and disturbing to Senators and to seniors. We are seeing double, we are even seeing triple, rates of premium increases in the cost of Medigap policies.

In my State of West Virginia seniors are paying increases close to 30 percent for their Medigap policies. Ironically, only a tiny percent of all West Virginians, maybe 3, 4, maximum 5 percent, would have paid as much as $700 for catastrophic benefits.

The majority would have paid no supplemental premium whatsoever—none. Yet the recent hike in Medigap premiums means that most of these same West Virginia seniors will be paying an average supplemental premium of $713 a year. So there is an irony there, folks, and it is not a very nice one; $713, incidentally, is up from $536 last year in West Virginia, which is an increase of $177 and that is a lot of money. Particularly, when you consider that 41 percent of seniors who have Medigap insurance have incomes of $5,000 or less.

I hope to learn more about this disturbing trend in Medigap premium increases this morning. And frankly, I would like to use this morning's hearing to look more closely at the overall Medigap insurance market. Seniors will spend roughly $10 billion this year on Medigap policies.

I want to explore the types of insurance policies that are being sold. Are seniors getting their money's worth? That is not an unreasonable question. Are they buying useless policies? Are they buying duplicative policies? What do they know about the policies that they are buying? Who is telling them? And why is it that 10 years after Congress—and here I point to my distinguished colleague, Senator Baucus, from Montana—10 years after the Baucus amendment established minimum standards for loss ratios—why is it that so many companies are failing to meet the minimum standard for loss ratios? A GAO study last year found that most commercial, non-group policies still failed to meet the targets established in the 1980 model standards for Medigap policies.

These are urgent questions facing us. Health care costs are spiraling. We simply cannot tolerate the sale of Medigap insurance policies that are overpriced or undervalued, especially not at these prices.

I would call now upon my colleague, the senior Senator from Montana, who, I know, is due on the floor for the Clean Air Act very soon.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator Baucus. Thank you, Mr. Chairman. Mr. Chairman, I think these hearings are extremely important this time, particularly upon the repeal of Medicare Catastrophic and more directly because of the very high increase in insurance premiums, and because the loss ratio minimums as provided in the earlier Baucus

Medigap amendments are not being met. That is, there are too many insurance policies being sold today where the loss ratios are below the minimums, particularly the 60 percent-provision, as prescribed in that bill.

Mr. Chairman. It is somewhat ironic that we are holding this hearing today because I remember back in 1980 when I offered the Medigap Amendment. It was a time when frankly I cut my teeth in dealing with a very, very difficult issue and dealing with the very strong opposition of basically many components of the insurance industry.

I pushed that Amendment because of many hearings held by Senator Claude Pepper. Senator Pepper held many, many hearings which very, very dramatically and tragically documented the number of instances when so many insurance policies were being purchased by seniors, innocent seniors, who frankly were being taken advantage of. It is for those reasons, that is, looking at that record and the hearing record that Senator Pepper established years ago—that led me to conclude that we had to set some standards, some minimum standards here. It was our hope then that these standards would take hold and have some effect.

Well we know from what we hear from seniors and we know from the evidence—you have outlined it yourself—that those standards today are inadequate.

They are inadequate for two basic reasons. One, consumers still are not sufficiently aware of the nature, particularly the loss ratios, of the policies they may or may not be purchasing. We need much, much better consumer education. Second, the provisions are not being enforced. They are not being enforced by HCFA; they are not being enforced the Department of Justice; they are not being enforced by the States. They are simply not being enforced.

Now Senator Pryor is going to be introducing Medigap legislation soon. I will be a co-sponsor of that bill, which will further remedy these problems. Here it is 10 years later—it is 1990—and Medigap provisions were enacted in 1980. I am also preparing legislation now that will increase enforcement of the existing Medigap regulations. It is clear that we have to take these steps if we are going to give seniors a sufficient degree of confidence and certainty that the policies they are buying are reasonably fair and that seniors are not being taken advantage of.

So as the author of the original Medigap protections, of the so-called Baucus amendment back in 1980, I commend you, Mr. Chairman, for holding this hearing. And as the Chairman of the Pepper Commission, I think you are doing a terrific job in trying to pull together some very difficult issues.

I also want to particularly commend my colleague from Arkansas, Senator Pryor, Chairman of the Committee on Aging, for his leadership. I look forward to joining and working with both of you.

Thank you.

Senator Rockefeller. Thank you, Senator Baucus.

Senator Durenberger and then Senator Pryor, then Senator Riegle, then we would we delighted to hear also from Senator Daschle and Senator Kohl who visits us today because of his own deep interest in this.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much.

I will try to be brief and just sort of set the group work, if you will, for the kinds of questions I would like to ask today. I think the questions I am going to ask will be directed principally at those who either provide or regulate the insurance market in this country.

The basic question is: What are you doing? What are you doing? What is it you are selling? What is it you are trying to convince the consumers of America that you are providing them? Is it insurance? No. There isn't anything in Medigap really that resembles insurance.

Insurance are insurable events, usually catastrophic. You cannot buy a catastrophic policy in this country all by itself anymore. I have tried for my folks. You cannot do it. You are selling them a lot of other stuff in the name of protecting their security. So please be responsive to what it is you are doing that resembles insurance.

Are you trying to hold down the cost of my parents or other consumers in this country? I do not see any evidence of that at all in the Medigap market. If there is evidence, let's talk about it during the course of the day today.

Are you trying to change provider behavior? I do not see any evidence of that at all in the Medigap insurance market. Are you trying to get the providers to change the way they address the problems of my parents and other elderly consumers? I do not see any evidence of that at all.

Are you trying to change my parents' behavior? The way they buy their health care, the way they protect themselves. I see very little evidence of that at all, mainly I see the opposite. You are trying to sell convenience against somebody else's product.

I say none of this critically—in a destructive sense. I say all of this from experience, having sat here with Max Baucus and others, Dave Pryor, since 1979, looking at the issue of the role of the insurance company in providing protection to people's savings and their investments and their earnings in accessing them to doctors and hospital services.

As a member of the Pepper Commission I have a serious concern for the future of what is called "health insurance" in America today. I must raise that today because we are within 4 weeks of making some recommendation. Our job is to guarantee or to suggest a system that guarantees financial access for every American into this wonderful medical and long term care system.

One of the issues you must ask yourselves—those of you in this business—is: What is your role in providing this access? Currently, most Americans look to you, but they are unhappy. So they are looking to Canada because they can get rid of you if they go to Canada. You do not have to have all these insurance products. You do not have to have these overaged movie actors trying to sell you their particular version of income security.

"Let's go to Canada," they say, "because we don't have to put up with all this stuff." There is no paperwork. There is none of the rest of this sort of stuff and there is happy Canadians they say. And there is only 7 percent of GNP.

I think you are getting a bad rap in the system. But unless you can explain what you think your most appropriate role is in the system of this country, I suspect those of us on the Pepper Commission are looking very, very closely at defining insurance for what it is—financial protection against a financial catastrophe.

All the rest of this stuff you are selling us, with the help of our employers, is not insurance. This is not an insurable event. Right here, three-fourths of the people in this room are going to buy this product at one time or another. This is not an insurable event. And yet, most of us have this or 6 month visits to the dentist or whatever in something called health insurance and you are still selling it to my 83-year-old father and my 78-year-old mom. And we are spending $550 billion a year doing that and they are buying four or five different products to make sure that they have that and we are all kind of confused.

So I suspect that my recommendation to the Pepper Commission is going to be a drastic change in the way we use third party payers in this country.

I suspect my recommendations will be that we set Federal standards for defining the products that we sell to the elderly in this country, that we rely on the States for consumer protection and the marketing functions and so forth, but that we start to set some Federal standards that are the same across this country, whether you live in Florida or Minnesota or Arkansas or West Virginia or South Dakota or Wisconsin or Michigan. Because people adjust their buying habits, their spending habits with regard to doctors and hospitals, the way in which they treat their ailments. It does not make any difference what State they are in.

So I suspect that will be one of my recommendations among many to my colleagues that I have already shared this with. But this is a very important hearing.

Some of us are angry because we assumed that when we did Catastrophic the rates were going to come down, instead they went up. Now that they have repealed Catastrophic, the rates have gone up again as the Chairman has said, and we do not understand why—and maybe part of this hearing is to get the answer to that.

But the bigger part of the hearing, for those of us up here, is what is the future of what we have called health insurance in America.

Senator Rockefeller. Thank you, Senator Durenberger.

Senator Pryor.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator Pryor. Senator Rockefeller, Mr. Chairman, I would like to submit my full statement for the record, if I may be permitted, and just to summarize a few points involved with it.

Mr. Chairman, I do not think I have ever attended a more timely hearing, a more timely subject in my 11 years in the Senate than this one today. What we have created out in the country is a state of total mass confusion and chaos with regard to insurance coverage—what you have, what you do not have and those items that are covered and not covered.

We are seeing this in my State—one insurer, for example, has now petitioned or applied for a 45-percent rate increase. Most of these premium increases, since the Catastrophic was repealed, average somewhere between 11-percent and 25-percent increase. We have created even, as I stated earlier, a larger problem of mass confusion.

I hope that I am not violating a confidence. But recently at a meeting of the Pepper Commission, those of us who allegedly are supposed to know all these insurance policies and all the health issues, one of our colleagues, Congressman Peter Stark of California, passed out to the 15 members of the Commission a sheet. It says, "Ladies and Gentlemen, what coverage do you have for these particular sicknesses, ailments, diseases, problems, et cetera?" We all flunked the test. I made the lowest grade in the room.

And if we, those of us who allegedly know these issues, do not understand these policies, what coverage we have, what have we created out there in this country for that elderly person who today is afraid, who is skeptical, who cannot know by any stretch of the imagination what they are being asked to buy, what they are covered for and what they do not have. And actually, the bottom line, what do they need.

Senators Heinz and Baucus, Daschle and Kohl and myself will be introducing legislation to begin an educational program. It will be called the Health Insurance Counseling and Assistance Act of 1990. Will it cost money? That's the first thing you ask in this town. Yes, it will cost money. It will cost approximately $15 million for the first year; $15 million for each of the 4 succeeding years thereafter; and then we will ask the States to pick up 100 percent of the tab.

It will give the States the ability to establish programs which emphasize the use of trained volunteers and to provide objective health insurance counseling to older Americans.

Will we utilize the area agencies on aging out there? I assume we will, Mr. Chairman. Because I think this is a proper approach to take. We also think that there is another great leader who has emerged in this area, and that person is not a member of this committee. He is a first-term Senator—Senator Kohl—who in December, only a week or two after Catastrophic was repealed, Senator Kohl went to Wisconsin, held a massive field hearing on this issue of Medigap and the cost of Medigap getting ready to rise.

I would like to salute Senator Herb Kohl for being truly a leader and to welcome him this morning, having been invited to sit with the members of the Finance Committee to look at these very, very complex issues.

Mr. Chairman, also to Congressman Ron Wyden who has been involved in this for a very long time, who has sort of been out there a voice in the wilderness, telling us what was going to happen. And now, Mr. Chairman, it is happening and Congressman Wyden has been absolutely correct. We salute you and we look forward to your statement.

Mr. Chairman, thank you very much for allowing me make my statement.

Senator ROCKEFELLER. Thank you, Senator Pryor.

Senator Riegle.

[The prepared statement of Senator Pryor appears in the appendix.]

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator **Riegle**. Mr. Chairman, thank you. Let me commend you for the great leadership that you are lending us, very specifically, on this subject today. I want to say to the colleagues that are around the table, I think the expressions of deep feeling and commitment to find some better answers is a hopeful sign, as I see it, that we are going to finally move on this on a national basis.

I want to report to you, Mr. Chairman, that in Michigan the rates on some Medigap policies have gone up as much as 45 percent just in the last few months. We are finding that an increasing number of seniors simply cannot afford those premiums; and, of course, this leaves aside the question of what coverage does it afford in any case. Is it the proper coverage?

I want to say to you, and urge others around the table, to move in the direction of what Senator Durenberger has said. I think that while we have a history of having insurance regulated and administered at the State levels, we have a pattern of 50 different approaches to those insurance questions. And as this relates to Medigap policies, which I think have a profound national impact, that we need some national standards and some national requirements so that people can understand what they are being asked to deal with, so that they get full value for their money. We have a situation where if people move from one State to another, as our population does at all ages of life, that they are going to find themselves incapable of making sense out of what is really, in many instances, a life protecting aspect of the decisions that they have to make with respect to health insurance coverage.

So I think it is a national issue. I would say to the industry, I think the industry has a responsibility to come forward in a consolidated way and address the question of how we meet what is truly a national issue and not put the issue off behind the complexity of 50 different State problems. We actually have, if you will, a pool of citizens out there that is 50 State wide and it is our entire country.

So I think—and I do not say this assuming that the industry will not come forward—but I think they have an obligation to and I would like them to do so on their own. And should they not do so then I think then that we will have to invite them in a way that is an irresistible invitation. But it should not have to come to that. They should step forward and present some ideas as to how we solve some of these problems to not only make sure that we are getting the proper coverage, but cost effective coverage.

Our seniors, I think, deserve that in this country. There is always a constructive tension between the public sector and the private sector. In fact, when we moved in with catastrophic health insurance we attempted to make public a part of the coverage which was private. This, of course, has since been rolled back. But I think the obligation in the private sector here carries with it a very important component of public responsibility.

So I want to hear from the industry as to what they feel they can do to help address these issues. We will work with them. If they do not want to respond, then we will lay out the plan for them.

Thank you, Mr. Chairman.

Senator **Rockefeller**. Thank you, Senator Riegle.

Senator Daschle.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator **Daschle**. Thank you, Mr. Chairman.

There is really very little to add except to join with those who commend our Chairman for taking the leadership in this issue. I do not know of anyone in the Senate who has devoted more time and who has given us more leadership on health matters than the Chairman and our ranking member. I appreciate their leadership, as well as the leadership by our first witness, Ron Wyden.

He is really a remarkable spokesman on health care issues and a dear friend. I appreciate his being here this morning.

I have three concerns. The first concern, which has been addressed quite a bit this morning, is related to cost. I can recall the debate so vividly last fall about the repeal of Catastrophic. We repealed Catastrophic largely because people did not want to see an increase of some $200, for about 80 percent of those who were affected.

Well we have repealed it. They are not going to pay $200; instead we are going to see up to 50-percent increases in Medigap insurance. I think it is a fair question. Why? Why are the costs going up as dramatically as they are? And what are people getting for it?

The second concern I have is the one addressed by Senator Baucus. I do not think that we have done an adequate job of asking the States why there has not been better enforcement of regulations; why with the laws that are on the books are some of the things happening today with regard to Medigap. I hope these hearings will give us some of the answers.

The third question or concern addresses the lack of information—the confusion on the part of so many people that I talk to in South Dakota and elsewhere. They do not understand loss ratios. They just understand they are paying out a lot of money and seemingly not getting very much back.

I think there really has to be some focus on the issue of that confusion. Consumer protection, if you will: understanding why we are not meeting the Baucus guidelines set out in 1980, why we are not doing a better job in providing benefits, why there is such a disparity in companies and in certain policies.

I hope we can address these questions, get some answers to them and then make some changes.

I thank the Chairman for taking the leadership this morning in doing so.

Senator **Rockefeller**. Thank you, Senator Daschle, very much.

Senator Kohl, you have been referred to in glowing terms and quite properly so. We welcome you to the Finance Committee.

STATEMENT OF HON. HERBERT H. KOHL, A U.S. SENATOR FROM WISCONSIN

Senator **Kohl**. Thank you very much, Senator Rockefeller. I am very pleased to be here as a guest of your committee. I appreciate the invitation. I am on Senator Pryor's Special Committee on Aging and he has been, as you can tell from what he said about me, a special friend, very kind to me, overly kind to me since I came to the Senate over a year ago, which I much do appreciate very much.

I did hold a hearing in Wisconsin a month and a half ago and many of the things that you are all aware of were very clearly and aptly laid out in front of me and those of us who were there.

We do have a Medigap insurance industry which is in disarray and the people who are getting hurt, of course, are elderly who are buying policies that they are not comfortable with, do not know what they are getting and are overpaying. I guess they are asking a question that I would like to pose here. Which is: Why is it that we here who are sitting at this table, and who are responsible for writing legislation and seeing it enforced, are not doing our job?

I mean I do not think that it is impossible, certainly after ten years now that we have been working on this, to see to it that we have legislation that is fair, that covers the Medigap insurance program and that it is enforced. I think what we need to concentrate on here is seeing to it that our obligations and our responsibilities to the elderly people of America are discharged and we do that best by first of all enacting legislation that is clear, precise, brief and to the point; and then seeing that that legislation is enforced.

I hope very much that the hearings we have here today will help to move us on down the road toward that conclusion which is so important to people who are elderly in this country. I am very pleased to be here.

Thank you, Senator Rockefeller.

Senator **Rockefeller**. Thank you, Senator Kohl.

I now invite to the witness table Congressman Ron Wyden from Oregon, who has been, I think, adequately praised. So his words now will justify all that has been said about him.

We welcome you.

STATEMENT OF HON. RON WYDEN, A U.S. REPRESENTATIVE, FROM OREGON

Representative **Wyden**. Thank you very much, Mr. Chairman. I too would ask to have my statement put in the record and perhaps I could just highlight some of my major concerns.

Senator **Rockefeller**. Please.

Representative **Wyden**. I am particularly pleased because obviously today has really assembled the who's who of health policy in this country. I am very pleased to see my personal friend, Tom Daschle—my neighbor—and I want to thank him for his kind words and his leadership.

You, Mr. Chairman, have taken the lead on so many health issues. And this remarkable physician payment reform that you pushed so hard on I think is going to make an enormous difference.

Dave Durenberger and I have had a chance many times over the years to work on health issues. It is a pleasure to be with him and with all of you.

Mr. Chairman, it is quite obvious that millions of seniors are spending billions of dollars each year on Medigap policies and many are being ripped off and being cheated out of their limited fixed incomes.

It really happens three ways. Seniors get preyed on by agents who play to their fears—fears that they are going to be left with crushing health bills. Many of the policies pay out less in benefits than 50 cents for every premium dollar. And every single person in this room has older relatives and friends who have duplicate coverage. We know it is not uncommon to find older people with a whole shoe box full of policies.

What really makes me angry, Mr. Chairman, is that the Medigap insurance lobby knows that lots of consumers are being fleeced and yet they consistently inform policymakers otherwise. For example, John Matthews, senior counsel to the Health Insurance Association of America, told the New York Times, February 6, 1989, and I quote, "Our research indicates that there is a large number of people with more than one policy—30 to 40 percent."

People have three, four, five, six, seven policies and it just does not make sense. There are a lot of people out there who do not know what is going on. But the Association's testimony that was submitted today says that there are only, and I quote, "occasional incidents of abuse." I just think for the Medigap lobby to say that there are only "occasional instances of abuses" is like saying that foxes are only occasionally interested in chickens. It is misrepresentative and I hope that we will follow up, as Senator Durenberger and Tom Daschle, and others, have said they are going to.

Now a number have mentioned here that there are laws on the books. The reason question is: Why are these laws not working? I would submit that the Medigap mess has flourished because Federal regulation is a voluntary, unenforceable patchwork of legal mumbo/jumbo. It is essentially more loop hole than law.

Even if a State has its program certified as meeting minimum standards, there is no Federal requirement that Medigap companies that operate in that State meet those requirements. Under the one Federal Statute, 42 U.S.C., with criminal and civil penalties for exploiting seniors in the sale of Medigap policies, there has not been one single prosecution.

Hear that—not one single prosecution under the Federal statute. I would like to talk about that statute and make some specific remarks and a couple of recommendations. Under the statute the sale of duplicate Medigap policies is a felony. But the problem is, there are at least four trap doors and this makes the statute too vague to enforce.

For example, if an agent does not ask the beneficiary if she or he has other coverage, it is then okay to sell the beneficiary an unlimited number of duplicative policies. If the duplication is not "substantial" then multiple policies may be sold, but nowhere in the statute is substantial defined and the prosecutors have told us then that the statute is unenforceable.

If the policies all pay out some benefits, no matter how significant they might be, they can then be sold without limitation. And what may be the biggest abuse of all, Mr. Chairman and colleagues, is agents can sell duplicative policies to the Medicaid population—the people who least available to afford such waste.

I would hope at a minimum that we simply take that statute—it is at page 865 of the Social Security Act—and put a big "X" through those loop holes. Because I think that is one step that Congress can take that will have strong bipartisan support and really will help seniors this year.

The second point that I would mention is the loss ratio matter and many members have talked about the fact that many of these policies do not meet the 60-percent standard for individual policies; 75 percent for group policies. The General Accounting Office's most recent report on loss ratios confirmed that the majority of Medigap policies have loss ratios below those standards.

The Inspector General in a memo of February 10, 1987 summed up the loss ratio problem pretty well in my view. He said, "The fact remains that insurers are apparently making excessive profits. Even the 60-percent level appears excessive, considering that Medicare administrative costs run only 2 to 3 percent." That indicates that much of the insurers remaining 40 cents on the premium dollar is excessive.

Again, Mr. Chairman, with respect to the loss ratios, we have all kinds of trap doors in the language. We essentially use an expectation standard that the loss ratio be met, not actually what the loss ratio is. I think what we ought to do is make the loss ratio binding; make it enforceable; in effect, carve out these kind of trap door words that have resulted in this situation such as the Inspector General found, where 50 percent of the policies do not meet the standards.

Probably one of the most important issues then, Mr. Chairman, is the question of standardization. Current Federal law does nothing to facilitate true comparisons for purchasers of Medigap insurance. Although the National Association of Insurance Commissioners has established a model standard which States may voluntarily adopt, these standards allow insurers to offer unlimited variations in benefit packages.

So what you have is exactly what the senior council of the Health Insurance Association said, and that is widespread confusion, because people cannot make accurate comparisons. I would just say, any of us can walk into any senior center in our District or State and you will not find more than one or two seniors who will tell you that they can even begin to make a comparison between Medigap policies.

I think that we have to do is two things. One, we ought to pass Chairman Pryor's excellent bill in terms of counseling. And Senator Daschle and many of you are on that. We are anxious to do the same thing in the House. Chairman Dingell has told me that we want to work very closely with you all in doing it. I think that is a good step.

But I also think that we ought to require standardization in the language of the Federal Social Security Act. We ought to make sure that there's real competition as it relates to price and service, and not phony competition where in effect companies are deluging seniors with information that is incomprehensible and does not allow them to make intelligent choices.

Mr. Chairman, the last point that I wanted to get into is this question of the premium increases. Personally, I would support something that I do not think a majority of the Congress is ready to do. I would support opening the McCarran-Ferguson Act as it relates to Medigap coverage—just that area—and setting in some caps on what you can charge seniors. I think that would be the one solid way that we could protect seniors now, given the fact that all of us have mentioned that Medigap premium hikes are going through the roof.

I do not suspect that a majority of the Congress is ready to do that yet. But I want to be on record as saying that I would support it. I think a lot of the arguments that the insurers are making as to why they are raising the rates simply are not warranted when you look at the proof.

For example, the Medigap premium hikes far exceed the medical economic index. The medical economic index for 1989 was 8.5 percent; but what the members of Congress are hearing now is about 30 or 40 percent rate hikes. Only the Part A portion of the Catastrophic law was repealed which expanded the hospital coverage. Industry representatives repeatedly argued that the Catastrophic benefits accounted for only a tiny portion of their premiums.

HCFA data shows that only about 2,000 Medicare beneficiaries spend more than 150 days in the hospital. So the question we have to ask is: Since almost 90 percent of Medigap policies cover unlimited hospital stays already, and since the unlimited hospitalization and skilled nursing facility expansion were the only benefits to ever take effect, what is it that insurers now have to pay for that they haven't been paying for all along?

I just do not see any evidence that these rate hikes should be so far in excess of the medical economic index. There are other arguments, certainly, that have been made over the years. The notion of making up for previous year losses. I think that one of the central problems is that two-thirds of the States do not require any approval before rate increases for group policies may go into effect.

So one alternative to really opening up McCarran-Ferguson is for the Congress to direct that the States have some approval process for rate hikes before they take place. I am not sure that all the States will react positively to that suggestion, but that would be one way to get at this rate hike issue rather than just opening up McCarran-Ferguson for Medigap and putting a cap on it.

One more point, Mr. Chairman. I read in great detail most of the testimony you are going to hear today, and it consistently says from the industry, the Federal Government ought to get out. The problem is not our fault, and we are very concerned.

The fact is the Federal Government is already in. We went in earlier. The question whether we are going to do it properly or we are going to allow this essentially meaningless statute to be on the books. The States, many of them, are trying very hard. You are going to hear from an excellent Insurance Commissioner, Earl Pomeroy. But at best, State regulation is uneven and it clearly has not done the job. And if it had, we would not be hearing from our constituents as vociferously as we are.

The industry will basically say that this is not their problem—it is a problem due to rising medical costs and that they simply have to pass it on. I do not believe that is the case. In that rare moment of candor, the health insurance industry's Council said exactly what a lot of senior citizens advocates have been saying for some time.

I just forward to looking closely with all of you. Senator Pryor has been very gracious to let us in the House to work with him in terms of the legislation. We ought to close those gaps in the duplication statute, move to minimum standardization requirements, enforce the loss ratio and then I personally hope that we will go after the rate hike issue, either by opening up McCarran-Ferguson for Medigap or by making sure that the States are in a position to require approval of rate hikes before they go in.

I am going to break my filibustering off right here. You all have been kind and I appreciate the chance to come.

Senator ROCKEFELLER. Thank you, Congressman Wyden. I also, from my own personal point of view, want to thank you for the work you achieved on something that we are working on together—long-term care for the frailest of the elderly through Medicaid—and you got that into the House reconciliation bill last year. I appreciate that very much.

Are there any questions of the Congressman?

[No response.]

Senator ROCKEFELLER. If not, Congressman, I am very grateful to you.

Representative WYDEN. Thank you.

Senator ROCKEFELLER. Keep fighting.

[The prepared statement of Representative Wyden appears in the appendix.]

Senator ROCKEFELLER. Ms. Janet L. Shikles is the Director of Health Financing and Policy Issues at the General Accounting Office. We welcome you and look forward to your testimony.

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY TOM DOWDAL, ASSISTANT DIRECTOR

Ms. SHIKLES. Thank you, Mr. Chairman. I would like to introduce my colleague, Tom Dowdal, who is our Assistant Director for our Medicare work.

Senator ROCKEFELLER. We welcome you, sir.

Ms. SHIKLES. We are pleased to be here today to discuss the work we have done on Medigap insurance and recent developments related to Medigap. As you requested, we will be discussing 1990 Medigap premium increases, the percentage of premiums paid out as benefits in 1988 and recent changes in Federal and State regulatory requirements for Medigap policies.

During the debate surrounding the repeal of Catastrophic, concerns were raised in the Congress about the effect repeal would have on Medigap premiums and how these additional premiums would affect low income, elderly persons. We recently contacted 29 commercial Medigap insurers to obtain their estimate of their 1990 premiums and their reasons for these premium changes.

Twenty companies responded to our request in our December survey. These companies are listed in Appendix I to my statement. The policies sold by these 20 companies covered about 2.6 million policyholders. On average, they told us that their 1990 premiums will represent an average increase of 19.5 percent higher than premiums in 1989. The average increase is about $11 per month. The increases range from 5 percent to 51 percent. One company reported that it expected its 1990 premium to remain unchanged from its 1989 premium.

The companies attributed about half of the expected premium increases to general inflation within the medical sector of the economy, increased use of health services and higher than expected claims experienced in prior years.

The companies also attributed the other half of the increase to repeal of the Catastrophic Act. Changes required by repeal included additions to benefits, such as coverage of the Part A deductible, or reducing the policy deductible for Part B co-insurance coverage from $200 to $75, and administrative costs associated with repeal of the Act, such as modifications to policies and notices to policyholders.

The Blue Cross and Blue Shield Association has also surveyed its member organizations. Thirty-eight organizations responded, representing about two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent. The Association said that a 9-percent increase was projected prior to repeal of the Catastrophic Act. It also said that plan rate increases reflect numerous factors, including growth in costs and utilization, benefit changes and adjustments for prior rate inadequacies.

In addition to the issue of increasing premiums for Medigap insurance another area of congressional concern has been the percentage of Medigap premiums returned to policyholders in the form of benefits, or the policies' loss ratios. A loss ratio is computed by dividing the total incurred claims for a period of time by earned premiums for the same period. The result of this computation is usually expressed as a percentage.

The Baucus Amendment, which amended the Medicare law to establish Federal Medigap standards, set Federal targets for loss ratios for Medigap policies. The Baucus Amendment required, as a condition of approval, that Medigap policies be expected to have loss ratios of at least 75 percent in the case of group policies and at least 60 percent in the case of individual policies.

The Catastrophic Act revised the Baucus Amendment to require States to collect data on actual Medigap loss ratios. In an earlier report, and at previous congressional hearings, we have reported on the loss ratios of Medigap policies. Generally we have found that pre-1988 loss ratios of most commercial policies did not meet the minimum standards. In contrast, the pre-1988 loss ratios of Blue Cross and Blue Shield and Prudential were generally above the standards.

In connection with work we are currently doing for two committees of the House of Representatives, we have obtained 1988 loss ratio data for Medigap insurance from NAIC and Blue Cross and Blue Shield. The data are reported in aggregate for all policies sold by the company. As in our earlier report and testimony, we found again that many companies' loss ratios are still not meeting the minimum standards.

In 1988 the loss ratios for companies with policies in force more than 3 years were based on total earned premiums of approximately $3.7 billion. For policies sold to individuals, by commercial insurers, about one-third of the company loss ratios were still below the 60-percent minimum standards. Among the Blue Cross and Blue Shield plans all but one were meeting the standards.

For group coverage about two-thirds of the commercial company loss ratios were below the 75 percent minimum standards. Among the Blue Cross and Blue Shield plans for group policies, 24 percent fell below the loss ratios that were required.

Under the Baucus amendment, States are responsible for monitoring whether Medigap policies meet the loss ratio standards and for taking actions when they do not meet these standards. We are hoping that with the new way of reporting data and the changes brought about by the Catastrophic Act, the States will assure that insurers meet these standards.

Another congressional concern related to Medigap over the years has been marketing abuses and consumer protection against those abuses. NAIC made some significant changes in December which should, if the States adopt these changes and aggressively enforce them, move toward alleviating some of the problems in multiple policy purchases and incentives to duplicate policies that have occurred in the past.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

Senator **Rockefeller**. Thank you very much, Ms. Shikles.

I will start with a rather long question. Generally, you have said that the main causes for the increases in the cost are increased utilization and increases in the Medigap insurance companies administrative—marketing, et cetera—costs and the rest is profits. You would agree with my assessment?

Ms. **Shikles**. Yes. And also adjusting for prior year experience.

Senator **Rockefeller**. Right, and repeal of the Catastrophic law.

According to CBO, Medicare's costs will increase about 10 percent this year. So would it be reasonable to say that the cost of Medigap premiums should increase about 10 percent?

Ms. **Shikles**. Yes.

Senator **Rockefeller**. In addition, Medicare is no longer covering the Part A catastrophic costs. I believe that HCFA had estimated the actuarial value of those benefits last year at $65. So insurance companies, on average, should have raised Medigap premiums another $65 on top of the 10 percent. Would that not be right?

Ms. **Shikles**. That would be right.

Senator **Rockefeller**. Also, the minimum standard for Part B coverage changed slightly. Companies must now cover Part B expenses after a $75 deductible instead of a $200 deductible. That is correct, is it not?

Ms. Shikles. That is correct.

Senator Rockefeller. Do you have any idea how expensive that change is?

Ms. Shikles. Well, we do not have any data on that. For those companies that would have had to lower their deductible, that could be expensive. But most policies already were either providing first dollar coverage or were already providing coverage after the $75 deductible. So it should not affect that many companies.

Senator Rockefeller. All right.

As for the repeal of the Part B benefits themselves, we repealed those before they in fact ever took effect. So since Medicare never covered these costs to begin with, they should have already been in the rate base for Medigap. Is that not correct?

Ms. Shikles. That is correct.

Senator Rockefeller. In other words, did the repeal of Part B catastrophic coverage itself contribute to the increase in the costs of Medigap premiums?

Ms. Shikles. No.

Senator Rockefeller. Finally, adding all of these factors up, a 10-percent increase in cost and utilization, another $65 for restoring Part A coverage, and some small administrative costs on top of that, do you think we can tell our constituents with a straight face that 20 to 30 percent increases in their Medigap premiums is reasonable?

Ms. Shikles. Well there is just—the other factor that is unknown is how much they are also adjusting for the prior year's experience, whatever they paid out in benefits. We have not looked at the data behind these different factors for their rate increases, so we cannot tell you if they are justified or not.

Senator Rockefeller. But you answered all the previous questions rather crisply and then you came down to the last one and would not take a position on that. I mean you actually said that—when I said, should there be anything more than the 10-percent increase if there is only a 10-percent increase in the cost of Medicare you said yes. But then we added in some other factors and I said is it reasonable that it should be a 20 to 30 percent increase in premiums you said, you do not have that data.

I am not sure if you are being as clear as you could be with me.

Ms. Shikles. Well many of the rate increases seem very high. What we do not know, because we do not have access to that data, is how much they are adjusting—the only unknown factor, other than the ones you have mentioned, is how much they are adjusting for whatever they paid out in the previous years. In some plans if they had miscalculated and paid out over 100 percent of earned premiums, the plan would then need to make some adjustment.

Because we do not have access to that data, I cannot tell you. You would have to go plan-by-plan.

Senator Rockefeller. All right.

Another subject. Do you know of any instance where a Medigap premium increase was turned down or denied by an Insurance Commissioner in a State because the policy had a loss ratio below 60 percent?

Ms. Shikles. In our previous work we have not found any examples of——

Senator ROCKEFELLER. Not a single instance?

Ms. SHIKLES. No.

Senator ROCKEFELLER. You have testified that Blue Cross and the Prudential Medigap policies have higher than minimum loss ratios. They are very dramatically—very, very dramatically higher.

Do you know what portion of the Medigap market is represented by Blue Cross and Prudential?

Ms. SHIKLES. It is about two-thirds.

Senator ROCKEFELLER. All right. Therefore, it is, obviously, the majority of the market. If the majority of the Medigap policies sold can operate with loss ratios above 80 percent, which both of those do, what are the extenuating circumstances for the commercial insurance companies not to be able to operate at that level or at least at 60 percent, which would make sense to you?

Ms. SHIKLES. There are no reasons that would make sense to me.

Senator ROCKEFELLER. Senator Pryor.

Senator PRYOR. Mr. Chairman, you are on a line of questioning there that I think is very, very important to this hearing. Would you like to continue with that line of questioning before you move to another area or would you like to continue?

Senator ROCKEFELLER. Will you grant me another question or two?

Senator PRYOR. Absolutely.

Senator ROCKEFELLER. All right.

Under the revised Federal loss ratio standards, according again to your testimony, States should be able to better enforce standards. Is this because of the revisions alone or do you have other information about State enforcements?

In the State of West Virginia when I was Governor we had about 18 people working in the Insurance Department. It was never my impression that State Insurance Commissioners had either the manpower, and in some cases the will, to act. I think of them as rather more vulnerable.

Your views?

Ms. SHIKLES. They could have acted in the past, but the data was a little bit obscured. With recent changes and the new data coming in, it is very clear whether actual loss ratios meet the standards. It should be very obvious and you would not need a lot of staff for a State Insurance Commissioner and Department to look at the loss ratios of a company and its policies.

If these loss ratios are not meeting at least the minimum standards they could take action on rate increases.

Mr. DOWDAL. Mr. Chairman, what we were saying in our statement is that we believe that the changes will make it easier for a State to enforce the federally required standards. Whether or not a State takes action because it is now easier, we cannot say.

Senator ROCKEFELLER. To what extent do companies underwrite in the Medigap market?

Ms. SHIKLES. We do not have—and I do not know that anybody has—definitive data on that. But if it occurs, if companies screen, it could really cause problems for companies that have open enrollment policies that take anybody. Because you could screen out somebody who is likely to have high expenses.

Senator ROCKEFELLER. Yes, which comes to my next and—I think, Senator Pryor—last question on this. Do you have evidence of the effect of medical underwriting on Medigap premiums?

Is it reasonable to assume that medical underwriting leads to adverse selection, as you have indicated, for companies with open enrollment policies, and could that drive up premiums for those that have open enrollment policies?

Ms. SHIKLES. I would think so. Yes.

Senator ROCKEFELLER. Okay.

Senator Pryor.

Senator PRYOR. Yes. Thank you, Mr. Chairman.

You have several Senators here this morning from the committee and, of course, Senator Kohl is a guest of the committee—a very important guest. Now we are trying to find some answers. We certainly see rising health costs. We certainly see increasing Medigap costs for the insurance policies.

But what we really see out there is mass confusion of patchwork from State to State, entity to entity, differing rules, regulations. But you have some people right here that really want to do something. Now, what should we do? Put yourself in the place of a Senator who sees the problem. Could you give us a suggestion of what you would do if you were in our place?

Ms. SHIKLES. Well I personally think that you could raise the minimum loss ratio standards. As Senator Rockefeller was saying, there is really no reason these companies should not be providing more benefits. As I reported, we found many companies not even making the 60-percent minimum benefit. So what that 40 percent represents basically is marketing and profits.

So I think it would be helpful to somebody—my parents, your parents—purchasing one of these policies if you raised the minimum loss ratio standards.

Senator PRYOR. All right. Who monitors that?

Ms. SHIKLES. They are monitored at the State level.

Senator PRYOR. Is there an adequate—this relates to the line of questioning of Senator Rockefeller. Do we have the mechanism, do we have the people out there, to do the proper monitoring?

Ms. SHIKLES. Well——

Mr. DOWDAL. I think that would, again, vary by State. I am sure that some States are able to do a lot more than other States. One thing that you could consider is the way rates are filed in a State. In some States, insurers can file a rate and it goes into effect and there is not much an Insurance Commissioner could do, except trying to do something retroactive after it has already gone into effect. That is pretty hard to do.

There are other States where insurers file and then in a certain period if the State does not say anything, it goes into effect. A third kind is where insurers have to have prior approval of a rate change.

So at least the ones where it is the file and use kind of method of doing it, you know, there is not much an Insurance Commissioner could do to try and fight with the company to get something done after a rate has already been put into affect and the premiums are being paid at that amount.

Senator Pryor. In your investigations thus far into this issue, are we beginning to see quite a few bad eggs getting into the Medigap business? Are we seeing some, say, fly-by-night companies moving into this for a profit?

Mr. Dowdal. Well I would think that anybody who is not meeting the minimum standards would not be acceptable to the Congress because the Congress said they have to meet that. There are plans that have been going on for years and years that have never met the minimum standards, which are fairly low standards.

Ms. Shikles. So maybe back to your point, it could be required that all States consider rate increases, not automatically approve them, that you have to first consider the rate increase, then look at the performance of the company's policy to see whether it is even meeting these minimum standards which are already low. And maybe consider raising the standards, and then also consider simplifying or requiring some standardization of what is sold.

Senator Pryor. At the conclusion of your testimony and after you leave and maybe have the weekend to think over that, please feel free to submit for the record any thoughts that you might have as to what we might do. I would value very much your suggestions.

Senator Pryor. Mr. Chairman, I am going to yield back the balance of my time.

Senator Rockefeller. Thank you, Senator Pryor.

Senator Durenberger.

Senator Durenberger. First, thank you very much for your testimony and also for the fact that you are still doing such great work at GAO.

Ms. Shikles. Thank you.

Senator Durenberger. It has always been a compliment to us to have your presentations and your work.

When the insurance people come to testify they are going to talk about the issue of repeal of Catastrophic and they are going to talk about the benefit coverages that they must now—it says here, "All Medicare supplemental policies must now cover the following expenses that they would not have covered had Catastrophic remained in effect. The $592 in-patient hospital deductible; $148 a day for the 61–90 if in-patient day; $296 a day for 91–150; upon exhaustion of all Medicare hospital in-patient coverage, life time reserve days . . ." And then under Part B some of the co-insurance.

My question is: As you examined the rate increases that took place last year before they had to provide this coverage and this year, have you got some idea of how much of this sort of overall premium increases are actually attributable to the coverage requirements or lack of requirements in these policies and how much of it is for other purposes, such as the increase in the cost of the medical prices indexes and so forth?

Ms. Shikles. We only can report what the companies told us. We do not have access to their data. So in our current survey of the commercial Medigap insurers they basically felt that about 50 percent of their increase will be due to prior experience, increased usage, and inflation; and the other 50 percent to the changes in Catastrophic. And the Blues are saying that about two-thirds of their increase is due to the repeal of Catastrophic.

Senator **Durenberger**. All right. One of the things that bothers me, and I do not have the data on it, is why the rates went up substantially last year when they did not have to have this coverage.

Ms. **Shikles**. Right.

Senator **Durenberger**. Then their excuse was the inflation over utilization and all that sort of stuff. I mean I cannot quite figure that one out. Have you been able to figure that out?

Ms. **Shikles**. Well we would have looked to see serious drops this year because that is when the Part B coverage would have kicked in under Catastrophic.

Mr. **Dowdal**. Last year we did, in testimony, point out that the benefits that were going into effect in 1989 were not real substantial. We did not agree that all of the increases that were being proposed at that time were, you know, proper and everything. But we did not expect to see an actual drop last year.

This year we thought that with the Part B benefits becoming effective you would have had a very small increase in the Medigap premiums. As Senator Rockefeller said, those were in last year's premiums, so it is not really something new that they are covering. But if the Catastrophic Act had remained in effect we would have expected much lower increases than what are going on now.

What the companies are telling us, and what the Blue Shield Association says, is that with Catastrophic still in place they would have increases of 10 percent instead of the 20 or more percent they are going up.

But again, the Part B stuff has always been in there. It was not out.

Senator **Durenberger**. Thank you, Mr. Chairman.

Senator **Rockefeller**. Senator Daschle.

Senator **Daschle**. Thank you, Mr. Chairman.

I am still trying to get a figure in my mind. I have heard a lot of them bandied about. I followed Senator Rockefeller's questions and your answers up until we started talking about percentages and dollars. The 10 percent I understand. But then we were saying that there was a $65 a month expenditure and a number of other incremental increases in costs that I do not know were translated, at least not to my satisfaction or understanding, into percentages.

If you had to put a rough figure to the understandable costs to be incurred this year by the companies, what would it be? Are we talking 12 percent, 13 percent or something more than that?

Mr. **Dowdal**. The repeal of the Catastrophic Part A benefits was around $5 a month. And if a typical policy is $600 a year, say, $600 to $800 a year, you are adding $5 onto that. So that might be, you know, on a typical policy, it might be 6 or 7 percent. Plus you add the increase on the Part B on the per person basis.

Senator **Daschle**. Right.

Mr. **Dowdal**. You put those two together and that is what one would expect from a cost standpoint, from a benefit standpoint.

Senator **Daschle**. But you did not attach a figure to that Part B expenditure. What would that percentage be?

Mr. **Dowdal**. It would be the same percentage increase as the percentage increase in the Part B premium. They track 1 percent for 1 percent.

Senator **Daschle**. Right.

Mr. **Dowdal**. Because all the policies are covering is what the Medicare deductibles and co-insurance are.

Senator **Daschle**. What I am trying to understand is, we are told that the average increase is about 20 percent. Some of them go all the way up to 50 percent, I'm told. I am trying to get a better understanding as to how acceptable that is.

I mean, is 20 percent twice what it should have been? Is 10 percent more than it should have been? Is it exactly what it should have been?

Ms. **Shikles**. Well I think our point is that we reported, just from our survey of commercials, that the range of increase was from 5 percent to 51 percent and we feel that even 5 percent, if you looked at the company, may be an inappropriate increase, that you have to look at each plan and look at the loss ratio of the policy. If the policy was not even meeting minimum standards, say for individual policies of say 60 percent last year, they should not be getting even a 5-percent increase this year.

Senator **Daschle**. So in other words, there is no industry wide standard by which you can apply the increases and say this is fair. Is that what you are saying? You have to look at policy after policy and make that conclusion based upon what is offered.

Ms. **Shikles**. That is right, and what they paid out in benefits.

Senator **Daschle**. That is a very frustrating answer. It probably is the best answer you can give us, but it is not very helpful with regard to giving us an understanding.

Ms. **Shikles**. Right.

Senator **Daschle**. Obviously there is a myriad of policies out there. So what you are telling us is that in order for us to judge whether or not each one of these policies is appreciating more than it should we would have to look at the individual policy. That stands a little bit in conflict with what you were recommending to Senator Pryor, which I thought was a very appropriate recommendation—make sure that all of these policies meet the Baucus standards.

If we require that these companies meet the Baucus standards of 60-percent loss ratio, why can't we now judge each one of these policies against a certain standard for cost and premium increases?

Ms. **Shikles**. You could do that now. I mean we just reported the loss ratio data we just got in for 1988 and you would hope that the State Insurance Commissioners now are looking at these data and looking at these requests for these rate increases. This is something that could be asked of States—see if they are looking at the performance of the company and then determining whether the rate increases should be approved.

Senator **Daschle**. Let me try another question. A concern that I have had for some time relates to consumer information about loss ratios. I had proposed some legislation a few years ago that would have simply required the loss ratio to be stated up front, on the cover of the policy; an understandable definition of loss ratio and an explanation of how this policy does with regard to that definition.

It seems to me that is a pretty clear opportunity for a perspective consumer to judge the value of that policy. From your experience, would you subscribe to that kind of requirement?

Mr. Dowdal. I would think it would be useful information for people to know. I do not know how many people would actually use it. But, you know, any kind of extra information people can have when they are making a decision to buy a particular item is good for them to know.

So if they were told that, you know, in the most recent year for data available this policy had a loss ratio of 80 percent or 60 percent, that would help them make a better informed decision.

Senator Daschle. Do you share that view, Ms. Shikles?

Ms. Shikles. Yes, I do.

Senator Daschle. Thank you, Mr. Chairman.

Senator Rockefeller. Senator Kohl.

Senator Kohl. I would like to ask your opinion. Is the problem that we do not have rules and regulations at the Federal or the State level or that we are just not doing a good job of sorting them out and seeing that they get followed? I mean, do we need all kinds of new laws or do we need better enforcement of what we have on the books at the State and the Federal level?

Ms. Shikles. Well you certainly need better enforcement. The changes that NAIC made in December of 1989 would help in a very positive direction if States adopted these changes and then aggressively enforced them.

But as I reported, we are continuing to find that policies are being marketed to the elderly that are not even meeting very minimum standards and these are not difficult standards to meet.

Senator Kohl. But those policies are subject to regulation, aren't they?

Ms. Shikles. Yes.

Senator Kohl. So don't we—I mean I am trying to get something clear in my mind and my mind has told me so far that the problem is not that we have an industry that is not regulated at all, where it does not have rules that govern its conduct, but that to the extent that we have problems, the problems focus, not exclusively, but focus on the fact that the regulations that cover this industry are not being enforced at the proper level by the proper people.

Now is that statement considerable true?

Ms. Shikles. I think it is considerably true.

Senator Kohl. Would you say that, sir?

Mr. Dowdal. Yes. You have had standards for 10 years now. The standards at the beginning could stand some improvement. They have been improved. There are probably more improvements you can make in them. But the basic question now is: Is somebody going to enforce those standards?

Senator Kohl. Well if that is true, then why are we coming down so hard on the insurance industry? Why are we making them out to the bad guys?

Mr. Dowdal. I think people are supposed to follow the laws, whether or not somebody is watching them.

Senator Kohl. But there has to be—if there is no law enforcement fellow on the highway and everybody starts going 70 or 80 or 90 or 100 miles an hour, I think the average citizen would feel that it is the responsibility of the State or the City or the County to get the policeman out there.

Ms. Shikles. Well, it is clearly——

Senator **Kohl**. Do I misunderstand? I mean I am learning. I am here as a guest and I am learning.

Yes, ma'am.

Ms. **Shikles**. No, it is clearly two parts. But it first starts with the insurers. These standards have been on the books and many of their policies are continuing year after year not to meet these standards. At the same time the State insurance departments are continuing to allow these policies to be marketed in their States.

Senator **Kohl**. If a business goes about doing what it can do and if there are laws and it does not live up to them and nobody comes at them and says you have to change what you are doing, yes, you can blame the business, but that is not where I think the first concern should be; it should be a concern at the regulatory level. Wouldn't you say?

Ms. **Shikles**. I think there should definitely be stronger action at the State level. We have said that previously.

Senator **Kohl**. Good.

I thank you.

Senator **Rockefeller**. Thank you, Senator Kohl.

I would like to close with maybe one or two more questions. Having the appropriate information is so important. GAO is well respected and yet, in response to a question of Senator Durenberger, you had to say, you just do not have the information.

Linda Jenckes, who will testify shortly on behalf of the Health Insurance Association of America says that that particular Association is "comprised of competing companies and therefore it does not gather data on existing or proposed health insurance premiums of our members."

Do you have trouble getting information from other groups that you research?

Ms. **Shikles**. Well it depends on whether we have a legal right to access to the data and then whether they want to give us the data or not. We can obtain information that we have a right to.

Senator **Rockefeller**. If you need to have insurance industry information—inside information—how would you find out information about, for example, profit within an insurance company, marketing costs?

We have been talking here about whether the numbers add up to 20 percent or 30 percent; and my guess is they probably do. I think the real question is: On loss ratios, why are companies who are below standard on loss ratios, why are they passing on any increases in premiums? Isn't that the essential question?

Ms. **Shikles**. Yes, it is.

Senator **Rockefeller**. Can you answer that question? Should they be able to pass on any if they are below loss ratio?

Ms. **Shikles**. No, they should not.

Senator **Rockefeller**. Back on information, how do you get information from the insurance industry?

Ms. **Shikles**. We have no legal right of access to their data and they will not provide it to us. That is why we can survey them and ask them, what is your premium increase going to be and what is causing it and they can refuse to answer.

Senator **Rockefeller**. So if I were to ask you, for example, what percentage of the increase would be presented by profit, you would not be able to answer me.

Ms. **Shikles**. That is correct.

Senator **Rockefeller**. Do you have a hunch?

Ms. **Shikles**. I have a hunch.

Senator **Rockefeller**. What might it be?

Ms. **Shikles**. Well if I could see the company's loss ratio data, which I can look at, and if it is 60 percent, then the remaining 40 percent is almost all marketing and profits.

Senator **Rockefeller**. It strikes me as odd that administrative costs for Medicare, which is a $100 billion program, is usually between 2 and 3 percent. That is pretty efficient.

Ms. **Shikles**. Yes, it is.

Senator **Rockefeller**. So, you know, somehow the administrative costs, the expanded use of services by seniors, claims costs, et cetera, for insurance companies appear to be—a lot higher, or the effect of Catastrophic repeal had to be significant, or else a lot of that is represented by profit.

Ms. **Shikles**. I think if a company has a low loss ratio or 60 percent, then most of that money is either going to agents as a bonus to selling the policy or it is profit. They should have low administrative costs.

Senator **Rockefeller**. I appreciate very much the testimony of both of you. I echo what Senator Durenberger said, that GAO is first class and I admire you. Thank you.

Ms. **Shikles**. Thank you.

Mr. **Dowdal**. Thank you, Mr. Chairman.

Senator **Pryor**. Mr. Chairman, could I ask her one more question?

Senator **Rockefeller**. I am sorry. Senator Pryor has one additional question.

Senator **Pryor**. I apologize for this. I have just received a letter from a hospital administrator in our State. I do not know a great deal about it, but here is the bottom line. He is representing and speaking for an individual there in the State of Arkansas who came to him, showed him a letter that was received. We do not know who it came from. There is no real return address on the envelope. But you send it back to Regional Processing Center, Dallas, Texas.

Here is what it said: "A few selected insurance companies are now offering up to 100 percent special plans to pay what Medicare doesn't. Benefits allow $1 million a year per person at a very reasonable cost." Okay. This person receives the letter, fills out a postcard, sends it to whatever the Regional Processing Center is, Box 742048, Dallas, TX.

They never get any information on it. The next thing that happens is a salesman knocks on the door. What I think is happening is these mail order companies are selling a list, I bet, to very unscrupulous companies.

Now do you know anything about this? Have we sensed this out there happening now?

Mr. **Dowdal**. I have heard that this has been going on and there have been reported problems with those cold lead kinds of things.

Senator **Pryor**. This is the cold lead problem. I understand that some of these companies pay as high as $25 per name to get to acquire these names. Is this correct? Do you know anything about the figure?

Mr. **Dowdal**. No, I don't know anything about the particulars on it.

Senator **Pryor**. Well I frankly think that these types of activities should be turned over to the Justice Department. Because once again, you are living off the fear and the uncertainty.

Mr. **Dowdal**. It certainly sounds like deceptive advertising in the first place and then they are not even using it for advertising for a policy if they are just selling the name to someone else. It does not sound like a very nice operation.

Senator **Pryor**. Mr. Chairman, thank you.

I do thank our two witnesses for lingering a moment longer. That is all at this point.

Senator **Rockefeller**. Senator Riegle has a comment.

Senator **Riegle**. Mr. Chairman, I am going to submit my questions for this witness. I am very interested in hearing from the next witness that you have scheduled.

[The questions appear in the appendix.]

Senator **Rockefeller**. Thank you.

[The prepared statement of Ms. Shikles appears in the appendix.]

Senator **Rockefeller**. Actually, we are going to have the next two witnesses at the same time—Earl Pomeroy, who is president of the National Association of Insurance Commissioners and commissioner of insurance for the State of North Dakota and Dr. Thomas Rice, associate professor, department of health policy and administration, school of public health, University of North Carolina.

Mr. Pomeroy, perhaps you would lead off.

STATEMENT OF EARL R. POMEROY, PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, BISMARK, ND

Mr. **Pomeroy**. Thank you, Mr. Chairman. My name is Earl Pomeroy, North Dakota Insurance Commissioner, president this year of the National Association of Insurance Commissioners, and also serving as chair of our Medicare supplement task force. This hearing is a novel experience for me. Usually I do not feel battered and bruised until after the questions are over and now I feel battered and bruised right at the beginning.

I want to acknowledge, Mr. Chairman, that you have asked some very excellent, timely, probing questions this morning. We are seeing—millions of Americans are seeing—significant Medicare supplement increases. In my testimony I hope to provide you information that has been made available to Insurance Commissioners in terms of the substantiation for these increases, what we are doing as insurance regulators to make certain these increases are appropriate and also to address a number of very apt points made relative to marketing abuses which seem to have been endemic to this particular market place.

In the interest of time I will substantially summarize my statement. We are seeing rate increases in light of both the repeal of Catastrophic, but also reflecting ongoing medical inflation that runs well above the rate of general inflation. We indicated in our last testimony to this committee that the enactment of Catastrophic had had a positive effect on Medicare supplement rates, either reducing the premiums or if not reducing, offsetting a good deal of the increase which would have been required due to inflation and increased utilization patterns.

Naturally now, in light of the repeal of Catastrophic, those costs have rolled back onto the risk covered by the private Medicare supplement insurance. We are seeing in many States the amount of premium rate increases due to the increased benefits of light of the repeal, running in the 5- to 10-percent range. Premium increases commonly are seen running in the 15- to 25-percent range, reflecting the impact both of the repeal and ongoing medical inflation.

As insurance regulators, we provide rate oversight through two mechanisms. Sixteen States have prior approval jurisdiction. We have it in my State. I think it is important, and I would vigorously resist any effort in North Dakota to erode the prior approval authority that we have. I want to warn you, Mr. Chairman, and members of the committee, however, that I do not believe prior approval is a panacea to increasing premium rates. I believe a study of those States with prior approval and those States without would not reveal sharp distinctions in the amount of premium dollar that consumers are paying in those respective jurisdictions.

All of the 50 States, regardless of prior approval or not, now have rate review authority through the loss ratio mechanism. For most of the 1980's this loss ratio was only an expected target. As in the original Baucus standards, it is an expected loss ratio. Insurance Commissioners move to make that an actual loss ratio, adopting that as a model standard in 1987, which was picked up in the Catastrophic enactment and left in tact in light of the repeal. So now the loss ratio standards must be actual.

We have taken significant steps as insurance regulators to be able to improve our ability to enforce loss ratios. Our initial loss ratio reporting forms simply did not do the job. There were too many actuarial vagaries an insurance company could use as the defense against a premium reduction action in support of loss ratios.

I do want to put the loss ratio issue in perspective though, Mr. Chairman. Using the GAO data alone 94.2 percent of the premium dollars they reflect in their statement reflects premiums written by companies that exceed the minimum loss ratio standards. That portion of overall premium written by companies failing to meet loss ratio standards reflects 5.8 percent of market based on the figures in their statement.

So I want to make it very clear that most——

Senator Rockefeller. And there are basically two companies—two groups that provide that majority.

Mr. Pomeroy. That provide most of the Medicare supplement insurance for the people of the country. I mean most of the country is protected.

Now that does not mean that we as regulators do not have to vigilantly enforce loss ratio standards against the other companies.

But, again, nearly 95 percent of the premium dollar is written in marketing mechanisms that exceed loss ratio standards.

We have, I think, made tremendous strides just within the last year to address marketing abuses that have repeatedly continued to be a problem and plagued the senior citizens of this country. We believe that the language used in the repeal of Catastrophic picked up these new standards, which we call the Consumer Protection Amendments, and imposed them as part of the enhanced Baucus minimum standards. Therefore, we are confident that within a year to 18 months of this hearing the new consumer protection protections advanced by the NAIC will be the State law in every State in the country.

I will be happy to answer questions, Mr. Chairman. Thank you for hearing us.

Senator ROCKEFELLER. Thank you for being so precise.

[The prepared statement of Mr. Pomeroy appears in the appendix.]

Senator ROCKEFELLER. Dr. Rice.

STATEMENT OF THOMAS RICE, Ph.D., ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY AND ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

Dr. RICE. Thank you, Mr. Chairman and members of the committee. My name is Thomas Rice and I am an associate professor in the department of health policy and administration, in the University of North Carolina School of Public Health.

I am very pleased to be here today to discuss the market for Medigap policies, an area I have been studying for several years. As you know, about three-quarters of Medicare beneficiaries own these policies. And when you combine this with Medicaid coverage for the poor, 82 percent have some form of supplementation. But this means that 18 percent do not. Unfortunately, the 18 percent who do not have this coverage tend to be the poor and near poor, the very old, and those who are in poor health—those who need it the most.

The repeal of Catastrophic, I think, has made the ownership of these policies an absolute necessity once again. They typically cover many expenses not covered by Medicare—most importantly, the cost of the long hospital stays and the 20 percent co-insurance on physician allowed charges. Without this coverage an elderly person is at great risk of incurring high health care expenses.

I believe that a major problem in the market is that the people who are least likely to afford the policies are the ones who tend not to own them. When you ask them why they do not own policies most say that they simply cannot afford them.

The committee may wish to consider further increasing the number of disadvantaged elderly who have this coverage. One of the parts of Catastrophic that was kept was the part that required States to pay the premiums, deductibles, and co-insurance for qualified Medicare beneficiaries. I think this is an excellent step but it does not do anything about the people above the poverty line who may incur very high health care costs. Additional steps, either increasing Medicaid coverage to some of the near poor or giving some sort of incentive or subsidy to buy private policies, would be a way to improve this problem with the market.

Of course the focus of your hearing today is on the cost issue. As everyone has mentioned Medigap policy costs have been going up very fast. The most peculiar thing is that they went up so fast when Catastrophic was first enacted, not so much that they have gone up recently. This problem is further aggravated by the large increases in Part B premiums that beneficiaries have to pay through their Social Security checks.

I do think the committee should give serious consideration to raising the loss ratios from the 60-percent level to a higher level, such as 70 percent. The GAO numbers show that some of the companies, the bigger ones, are able to meet standards of 80 or even 90 percent, but the majority of the others fall below 60 percent.

Raising the minimum loss ratio would do one of two things. It would either make the companies with low loss ratios reduce their premiums or reduce their costs, perhaps by paying their agents differently, or it would drive them out of the market. But given that there is so many hundreds of companies that sell Medigap policies I do not think that even if some were driven out of the market that this would create much of an access problem for beneficiaries to the Medigap market.

Now another problem that has been touched on today is the difficulty consumers have in shopping for the most cost effective policies. Policies do vary very greatly in the benefits that they cover in addition to Medicare. Study after study has shown that consumers have terribly little understanding of their Medigap coverage.

One method of dealing with this would be to further standardize the market to have companies offer three or four standard policies to aid in consumers getting the best buy. This has been tried, as I understand, in a few States. Standardization would make it much easier for consumers to compare the premiums of different companies. I therefore believe that the committee should investigate this option. It just needs to be careful that the standards that it develops do not unduly reduce access to the benefits that beneficiaries would most like.

I also agree with what has been said today that good consumer information is the key. It is the key to the functioning of any market. The two areas where Medigap beneficiaries have the worse information are the areas of nonassigned physician charges and nursing home costs. The recent physician payment reform legislation, which this committee was so instrumental in implementing, should dramatically improve information with regard to nonassigned physician charges, but we still have a very big problem with people not understanding the lack of nursing home benefits available through Medicare and their Medigap policies.

Senator ROCKEFELLER. Why would they know more because of physician payment reform? Excuse me for interrupting.

Dr. RICE. Largely because their out-of-pocket costs for non-assigned services will be reduced. When the benefits are fully phased in, the most beneficiaries can pay in nonassigned charges will be 15 percent; now they pay much more. The legislation also has several incentives for physicians to accept all of their patients on assignment by becoming participating doctors. In addition to that, some Medigap companies pay on the basis of the insurance company's fee, rather than the Medicare fee. That often is 15 percent higher than the Medicare fee, in which case they would not have any nonassigned charges once the balance billing limits are fully in place. And finally, the fee schedule is much simpler than the rather haphazard CPR system that we have right now.

But the long term care problem is even a more pressing one. Medigap policies purport to cover stays up to a year in length. But in fact, this policy benefit is practically worthless because these policies tie their coverage to Medicare, and Medicare does not cover many nursing home stays—less than 15 percent. When it does cover them it cuts off, at which point the Medigap policy coverage is cut off, too.

But I think that the primary cause of the consumer misinformation is not the private insurance industry, but Medicare. This is because it is almost impossible for a beneficiary to understand whether Medicare is going to be covering their nursing home stays for a certain number of days or not. As I said, only about 15 percent of stays are covered at all by Medicare and usually for only a few weeks.

I think the most important step Medicare could take in informing beneficiaries of their large liabilities would be to eliminate the distinction between acute and long term stays and any other technicalities that prevent Medicare from covering the days it says it will cover.

In other words, Medicare should cover a set number of days. If this happens, given that Medigap policies are tied to Medicare, it will become clearer what Medigap policies will cover as well. That when consumers understand both Medicare and Medigap coverage for nursing home care, then they will be in a much stronger position to understand whether they should purchase long term care insurance.

Thank you.

Senator Rockefeller. Thank you very much, Dr. Rice.

[The prepared statement of Dr. Rice appears in the appendix.]

Senator Rockefeller. Mr. Pomeroy, I want to go back to the question of the State Insurance Commissions. I made what might be considered not the kindest of remarks. I come from a small State. I guess I am the only one here who comes from a small State. Department heads in most small States receive low salaries. I can remember in David Pryor's State, the Governor used to be paid $10,000 a year. I can remember a time when David——

Senator Pryor. I was paid $10,000 a year and they thought I was paid $5,000 too much. [Laughter.]

Senator Rockefeller. So the Insurance Commissioner—a new Governor has been elected and he is trying to find an Insurance Commissioner. Where is he going to go? He is going to go to the insurance industry. That makes sense. But it also raises questions, because the Governor may not be there after 4 years and the Insurance Commissioner has to keep that in mind. I am talking practical realities.

The GAO witness testified that she could not remember a single instance where a Commissioner had turned down a request for a premium increase on Medigap, even when that particular company was well below the loss ratio requirements or expectations—now requirements. That is a fairly severe statement.

Mr. **Pomeroy**. Mr. Chairman, I appreciate the opportunity to address that statement. Frankly, she was incorrect with her answer. I have turned down rate increases in North Dakota and my action is not unique to the country. Rate increases have been turned down. There are only 16 jurisdictions with prior approval authority, so I do not mean to overstate that. But rate increases are routinely rejected in those States where the underlying data or the accumulated loss ratios do not support the rate increase.

In States without prior approval jurisdictions there have been rate rollbacks retroactively imposed when loss ratio information has not substantiated the premiums that have been charged. Two recent ones that received some publicity in this area were taken in New Jersey with rate decreases in the 20- to 25-percent range imposed in light of the company's loss ratio record.

Another thing relative to Insurance Commissioners. We think we are getting better. There are 11 elected, soon there will be 12 with California. In those jurisdictions that appoint insurance commissioners, the positions become hot political property. This is not just because of Medgap—auto, and any number of lines of insurance—represent some of the greatest areas of political exposure a Governor has nowadays. The Governor can no longer either reward the industry for support or some political crony for loyalty. They have to represent and appoint a very competent public official to handle the array of challenges today's Insurance Commissioners face and I think that you have seen some improvement in our ranks.

Senator **Rockefeller**. All right. You are absolutely correct about New Jersey. I believe they ordered two Medigap insurance companies to lower their premium increases. I think New York has been active in that also.

Now you have used the word "routine." I need to ask something for the record because I want you to get back to me since you are president of this association.

Mr. **Pomeroy**. Sure.

Senator **Rockefeller**. We would like to have some really hard information on the number of instances where there have been denials or rollbacks in two cases: one, where people are at their loss ratio expectations or requirements; and then, also, where they have been below their loss ratio expectations or requirements.

Would you be willing to do that?

Mr. **Pomeroy**. Absolutely.

Senator **Rockefeller**. May I ask you, also, is Medigap a good buy?

Mr. **Pomeroy**. It certainly depends. I think that Medigap may be an important—particularly in light of the repeal of Catastrophic—is an important insurance protection to have in light of——

Senator **Rockefeller**. What factors should be in a good Medigap policy? If your mother, for example, considers whether or not to make that purchase, how would you advise her? What should she be looking for?

Mr. **Pomeroy**. If she can afford a more expensive premium she ought to be looking for a more expansive set of benefits. If her budget is tighter and she needs to purchase a more "bare bones" type Medigap coverage, loss ratio alone, it may be a helpful indicator but it isn't certainly the dispositive one. A company with a very high loss ratio, for example, may be in desperate need of a substantial premium increase in order to get their business back to a profitable basis.

So maybe the premium for that year would be good but the next year it would be substantially higher. So I would caution against an overly simplistic focus on loss ratio alone.

Senator ROCKEFELLER. Senator Durenberger.

Senator DURENBERGER. Thank you.

Earl, I am sorry I had to step out for part of your testimony. I am going to use a Minnesota example. Some of the things that Mike Hatch did while he was Commerce Commissioner and now Tom Borman has got his name on in doing consumer information type activities. I imagine this is the kind of thing that is very helpful around the country and probably a lot of Insurance Commissioners are doing it to help relieve some of the burden that the Senator from Arkansas has talked about in terms of consumer information.

But beyond that, in terms of the recommendations that the Commissioners are making for model laws, as I understand it in Minnesota we have done a lot to standardize benefits, to get down to high and low option only in the benefits area, to remove inappropriate incentives for churning by agents backing people out of policies every chance that they get and into new policies just to pick up the new premiums, trying to assure greater equity in the area of loss ratios and so forth. It seems to me my State has gone beyond the model laws and I am wondering what holds back other States from getting tougher requirements in this area.

Mr. POMEROY. Mr. Chairman, as the Commissioner in the neighboring State, I looked when I came into office to the activities of the Minnesota Commerce Department for instruction. Some of the ideas that have been implemented I used; some I didn't. Standardization, for example, there are an infinite array of financial circumstances represented in the Medigap market.

When you standardize policies you restrict a consumer's right to select a coverage that might be more uniquely suited to their particular financial needs. So I did not feel standardization was something I was comfortable with.

Minnesota had a suitability standard which requires agents to place with their clients only that coverage that the client needs. I thought that was a great idea and we did take that idea. Suitability, we now call it appropriateness, so it was not confused with suitability as used in security regulation, has been adopted in the Consumer Protection Amendments adopted in 1989 and I hope again will be law throughout the country, adopted State by State within a year.

Senator DURENBERGER. Again to get at the issue of who should be in this business and who should not, suppose we expanded—and I must say that the Pepper Commission is looking at this—the current underwriting requirements for insurance. For example, to make it impossible for people who sell an insurance product, or a so-called insurance product to exclude people for prior health conditions; to be more generous in community rating, rather than restrictive in the way they group rate their products.

If we were to suggest to the State Insurance Commissioners and State Legislatures that the definition required to get a product on the market would go into that kind of area as well, do you think we would see a bunch of insurance companies dropping out of the Medigap market?

Mr. POMEROY. Senator Durenberger, I think that you would restrict the market somewhat. I think some companies would leave and other companies that presently underwrite their business—which in North Dakota is virtually all of them—would find their premiums going up because they would be on an open enrollment basis accepting risks that are of a great likelihood to incur health claims.

So it would have an impact of raising premiums. Eighteen States have put in place some form of health risk pools to provide an insurance alternative for those individuals that cannot obtain coverage in the private market by virtue of having a health risk condition. That is how Minnesota and North Dakota have addressed this problem.

Senator DURENBERGER. I think you have answered the question. If we make it tougher for somebody to sell a product or their risk potential goes up, they are going to raise their premiums to everybody across the board. Right?

Mr. POMEROY. Yes.

Senator DURENBERGER. They are not going to respond to that by trying to ratchet down on the cost. Because in effect most of these people are just moving money around. They are not doing anything to affect consumer behavior or provider behavior or any of that sort of thing. They are just moving money from my mother's pocket through themselves, taking out 20 percent, 40 percent, 7 percent in some cases or whatever, and putting it into the pockets of doctors and hospitals and nursing homes.

They really are not changing the character of the relationship between the buyer of medical services and the seller of services at all are they?

Mr. POMEROY. Senator Durenberger, some companies have made more of an effort relative to cost containment and managed care than others. I am very critical of the major insurer in our State for having not done enough relative to keep costs down.

I do think that provider behavior is something that this committee also needs to look at. To an extent, focus on the health insurer is killing the messenger. Some of us believe that health care costs are rising out of control. And ultimately, in a private health insurance mechanism, those costs are going to be passed back in ever higher premiums. We have to have more self-restraint, I believe, in the medical provider community.

I think that insurers have to be more aggressive than they are today at enforcing that.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Senator Pryor.

Senator PRYOR. I am going to pass at this time.

Senator ROCKEFELLER. Senator Riegle.

Senator **Riegle**. Mr. Chairman, this is interesting testimony and exchange here. We have at the Federal level Truth and Lending laws that we adopted finally because it was so difficult for people to understand effective interest rates on home mortgages or what was being offered on savings accounts and so forth.

We also had to move in the direction of packaging laws in terms of content labeling of certain things as well. Because if we did not, there was really no uniform way for people to be able to know what they were getting in food products that they were buying. In fact, probably more is needed in that area. I want to relate that, in a moment, to how I think we ought to consider maybe changing the way we do things on these Medigap policies.

You note that only 16 States have prior approval. My guess would be—and you did not say you had the data to compare the 16 as a group as against the others, perhaps you do. If you do, then your group ought to do that to find out if we are gaining any efficiencies or cost benefits for consumers as a result of the prior approval. I think that is a large enough base to work from.

But my guess would be that in addition to whatever you might find there, that the fact that 16 States have prior approval works indirectly on the States that do not. I think it probably pulls people to a higher standard.

What I am wondering is this: What would you think of the idea of finding a standardized way on a national basis to put together component parts of health protection that a company, a private company, wants to offer? So that you would take a particular type of proposed benefit, you would standardize it and for this particular item, if you want this as part of the plan, it will cost so many dollars in premium; if you want a second segment which deals with a second tier of benefits or issue that would be covered, that that would be then in a second category and there would be a cost for that; and obviously, if you wanted section one and section two, then you would pay the total for both; and so forth on down the line so that you had a standardized set of benefits that people could add together or take part of in terms of sort of building blocks, but they would be uniform in definition across the 50 States, so that any private insurer that wanted to be in the business would offer that set of options.

With a standard list of items, there would be virtue in some uniformity. An then you would have your competition. If one company can come in and provide a package of those benefits more efficiently and less expensively than somebody else then good for them. They ought to get the business and they ought to grow. And the companies that cannot do it as well ought to probably shrink in size.

Why are we not at a point where something like that might be helpful to you and to other State Commissioners?

Mr. **Pomeroy**. Senator Riegle, that is a very interesting concept. Presently insurance is priced based—even in a prior approval jurisdiction, I do not have my actuary run a value of benefits and then affix a price. We look at the claims experience incurred on a policy and allow a premium increase based on incurred experience and projected experience into the future.

We attempted, in part, to do what you are suggesting and learned that it was not feasible. We wanted to have a break out of benefits and each benefit assigned a price in the policy solicitation material so an individual could pick and chose depending on what manner of benefits they wanted to put together.

We found that utilization patterns vary, depending on age group, depending on class of insureds for various benefits offered. It is, therefore, impossible, based on information we received, and were ultimately convinced by, to break out the benefit and set a price on it as precisely as you are talking.

Senator RIEGLE. What about a basic benefit package then? If you cannot do it in say four or five tiers that people can say yes or no to, then what about a single tier that would constitute something that most people like yourself, professionals in the field, would say is a good solid core package of Medigap benefits? What if we defined that and said all right, here is this package. It is going to be offered. Every company is being asked to quote a price on that in each of the 50 States. If they want to go beyond that and offer other things or variations of other things they can do it and then they go through your process and the customer has to make a judgment.

Why all the resistance? And I do not say that you are resistant to this. Why is it so impossible to get a standard package in plain language that can be offered and you get price competition and quality and service competition among the providers? Why is that so difficult?

Mr. POMEROY. To an extent, the Baucus standards do impose upon the States a minimum set of standards.

Senator RIEGLE. Impose?

Mr. POMEROY. We believe that they impose. For example, although it is, as described by Representative Wyden, whom I have the greatest respect for and he has done a great deal of good in this area, he believes they are voluntary certification standards. States do not see them that way at all. They believe that their State laws have to comply with the Baucus standards.

Prior to the enactment of Catastrophic 46 States had their statutes and regulations in compliance with Baucus. After the enactment of Catastrophic, acting within that 1-year time frame, 49 States brought their laws into compliance with the revised Baucus standards, taking cognizance of the enactment of Catastrophic. Now that Catastrophic has been repealed again we have again revised the Baucus standards. As I have mentioned, we have enhanced them considerably with the Consumer Protection Amendments.

I believe that each State feels they either need to enact these or they will be Federally imposed by virtue of the HHS—the certification responsibility imposed on HHS.

Senator RIEGLE. If I may—my time is up. I would like to make a second request to you. I made one and you were kind enough to note it. I trust you will get back to us as a national organization.

The second one is that I would like your group to try to generate, from the expertise that you have, a standard package, a Medigap package, that would be a recommended combination of core benefits that could be offered universally across the country that we might set up as a standard package that competing companies could then compete on price and compete on quality. I would like you to develop that and provide it for us.

Mr. POMEROY. We will bring you that, Senator.

[The information appears in the appendix.]

Senator RIEGLE. Mr. Chairman, I appreciate the willingness of the group to do that. I think that might be helpful to us.

Senator ROCKEFELLER. All right. One question from me and then several questions from Senator Pryor and if anybody else wants to.

Dr. Rice, why is it that Blue Cross and Blue Shield, AARP, and Prudential are able to meet loss ratio requirements? They are able to do that, but so many others are allowed to or simply fall so short of the loss ratio requirements? Why does it happen?

Dr. RICE. There are only three things that could result in a loss ratio of less than 1.00. There is general administration, marketing expenses such as advertising, and profits. My guess would be that in the companies you speak of there are substantially higher marketing expenses, partly through paying agents, and mass media advertising, compared to Blue Cross and Blue Shield and the AARP Prudential. It may also be higher profits. But primarily it is the large difference in marketing costs.

Senator ROCKEFELLER. So it is more than economies of scale? They may have different marketing costs for example?

Dr. RICE. Yes, economies of scale would have been my third choice. I think that marketing expenses and profits would be a much bigger component.

Senator ROCKEFELLER. And different mechanisms of marketing?

Dr. RICE. Yes.

Senator ROCKEFELLER. For example——

Dr. RICE. Like television advertisements, more newspaper advertisements, direct mail. There is more of that going on in the companies that have very low loss ratios.

Senator ROCKEFELLER. Thank you.

Senator Pryor.

Senator PRYOR. Yes, thank you, Mr. Chairman.

Mr. Chairman, a moment ago I asked our witness from the General Accounting Office about the "cold lead" problem. I hope the Commissioner was in the room at that time.

Mr. POMEROY. Yes.

Senator PRYOR. Are you running into many of these problems about the cold lead issue whereby their names are sold to insurance companies and then the next thing they do not get any information in the mail but they get a knock on the door? Is this growing?

Mr. POMEROY. Senator Pryor, my own mother has had an experience with cold lead, resulting in an agent solicitation at her home. It is a phenomenon that has been a prevalent one. If it was growing, I do not believe it will grow further. We have prohibited companies from contracting with vendors of cold lead advertising devices as part of the Consumer Protection Amendments.

We believe that activity gets squarely into misleading advertising and misleading solicitations, clearly inappropriate; and we intend to simply prohibit it and enforce that as strictly as we can.

Senator PRYOR. Mr. Chairman, a moment ago I made mention of a specific case whereby the person was supposed to reply to the Regional Processing Center, Box whatever in Dallas, Texas. I just stepped out to the phone to call the Regional Processing Center in Dallas. Not only is there no such company listed there with a telephone, too there is no address for such a company. This was a very recent communication in the last 2 or three weeks.

We are also now, from the Committee on Aging, they have just brought me a little stack, there is also a group—I did not know this—the National Association of Retired Persons. That is the NARP. They are sending out all kinds of propaganda to senior citizens.

All I am saying, Mr. Commissioner, is we want to work very closely with the Insurance Commissioners on this. But I think we are about to see a very large growth in the fraud industry here. I hope we will police it together and I hope that we will certainly look at it very, very carefully. Because the potential for fraud and abuse is enormous.

Mr. POMEROY. Senator Pryor, I believe that the NARP—I will acknowledge that I think that State regulators were slow to address the marketing abuses. The original Baucus standards addressed product design and we did not address adequately marketing abuses. Last year we addressed them with the Consumer Protection Amendments. They are outlined in an attachment to the testimony I have presented.

I feel as though we have done a fairly comprehensive job of addressing these. It is now for State Legislatures to adopt them. I would be interested if the industry representatives to testify following me would indicate their support of those Consumer Protection Amendments. If they do truly support State regulation, then they should help us get those essential protections on the State laws as soon as possible.

Senator PRYOR. Thank you.

Senator ROCKEFELLER. Thank you very much, both of you. You have been very helpful. We appreciate your testimony.

Our next panel will be Alan Spielman, who is the executive director of Government Programs Legislation, Blue Cross and Blue Shield Association; and Linda Jenckes, vice president, Federal affairs, Health Insurance Association of America. We welcome both of you.

Linda, perhaps you could start.

STATEMENT OF LINDA JENCKES, VICE PRESIDENT, FEDERAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC, ACCOMPANIED BY ROBERT SHAPLAND, VICE PRESIDENT, MUTUAL OF OMAHA

Ms. JENCKES. Thank you, Mr. Chairman. With me today is Bob Shapland, a vice president of the Mutual of Omaha. We will both be delighted to answer any questions that you may have after I complete my statement.

What I would like to do is submit the statement in its entirety for the record and highlight if I may.

Senator ROCKEFELLER. Please.

Ms. Jenckes. We appreciate your interest as well as that of the rest of the members of the subcommittee in the effect that changes in Medicare have had on senior citizens. When the Medicare Catastrophic benefit was enacted we received many inquires from concerned senior citizens wanting to know how their benefits, taxes, and Medicare supplement premiums would be affected. We are experiencing, as you, the same phenomenon again now that the Act has been repealed.

Our member companies are indeed working with State insurance regulators to implement appropriate benefit and premium changes in their supplemental policies for 1990. We are committed to assuring a smooth transition for all Medicare beneficiaries. I am pleased to report that to date all deadlines have been met.

The GAO did just testify on the average increase in commercial insurance companies premiums for this year. We do generally concur, based on our predictions, that that is 19.5 percent.

What I would like to do is just look at some of the specific factors due to the repeal of the Catastrophic law in 1990. All Medicare supplement policies, in addition to the other benefits that they have to provide, must now cover the following expenses that they would not have covered if Catastrophic remained into effect.

On the hospital side, either all or none of the $592 in-patient hospital deductible. It is my understanding that the majority of our companies will indeed be offering that deductible in terms of coverage this year. In addition, are the other Part A benefits which I will not outline because they are contained in the testimony. In terms of Part B or physician services, we are required by State law to cover all co-insurance amounts. That is the 20 percent of Medicare approved charges under Part B, regardless of hospital confinement, and subject only to an annual deductible of $75 for 1990.

In addition to these benefit changes, the repeal also generated significant administrative costs for insurers because of the need to revise policies, file them for approval by State regulators and notify policyholders.

Another point that I would like to make is that some policies do indeed offer benefits beyond the minimum required benefits. These most often include out-of-hospital drugs, skilled nursing facility copayments and physician charges in excess of Medicare-approved charge levels or what is commonly referred to as balance billing.

The cost of these optional benefits are also increasing. While the Catastrophic program last year may have had some offset on the cost of these benefits, their effect on premiums must now be recalculated this year due to the repeal of the Act. The effect of increasing medical costs is another major factor. The majority of claims dollars paid out by Medicare supplement insurers are for the 20 percent of Medicare-approved Part B charges, which are the beneficiary's responsibility to pay. Simply put, due to rising physician fees, more services being provided the elderly, the higher cost of new technology and the fact that many procedures which used to be done in hospitals are now done in doctors' offices, Medicare Part B payments have grown from $13 billion in 1982 to $37 billion in 1989, a compounded rate of 16 percent a year.

It is estimated that the rate of increase will continue in 1990, resulting in payments by Medicare of about $43 billion for seniors covered under Part B. Again, insurers are liable for the 20-percent co-payment as required under State law. So, we are experiencing similar increases in our claims payments.

But the cost per claim in not the only problem. The number of claims is also rising. We believe that the increasing volume of Part B claims received by Medicare and supplement insurers is due in part to the debundling of services by providers.

A shift away from in-hospital treatment to out-patient procedures has also had the effect of increasing beneficiaries and supplemental insurers' costs. We believe that we need nationwide solutions to cope with rising expenditures and we are pleased that the Medicare physician payment reforms enacted as part of the Reconciliation Act, in which this committee played a major role, will be coming into force soon. We feel that that is going to be a major factor in containing costs.

What I would like to do is just highlight a few other cost factors which I feel that the committee should consider because they are important when we calculate our premiums. That is, we must look at the specific benefits provided in a policy; the age of the policyholders; the past claims experience for the policy; and the regional variation in health care costs, as well as the company's operating costs, including the way it markets its policies.

In turning to the subject very quickly of how Medicare supplements are regulated, I think the initial point that I would like to make is that Medicare supplements are clearly one of the most highly regulated forms of health insurance, offering the Medicare beneficiary substantial consumer protection.

My testimony contains many of the specifics but I would like to just highlight a few requirements which we supported as they made their way through the process. These new State requirements will be implemented through the regulatory process of the legislative route, depending on what a state's existing authority is.

Individuals purchasing Medicare supplement insurers cannot now be canceled for any reason except for failure to pay the premiums or for material misrepresentation. People will no longer be subject to loss of coverage because their membership in a group ceases or the group policy itself terminates. They will be offered continuation of coverage through an individual policy.

Also, the number of Medicare supplement insurance polices that an individual may purchase or an agent or company may sell, in effect, has been reduced to one. There should be no more duplication of Medicare supplemental policies in the marketplace. There are various reforms and requirements imposed on insurers to make sure that is the case.

There are additional new requirements which I also think are very important. One is that an insurer would be prohibited from imposing any new preexisting condition limitations or waiting periods for similar benefits in a new policy once an individual has already been in the marketplace. What that basically means is that an individual still has the right to replace that policy but they will no longer be subject to a preexisting condition.

There are also limits that are placed on the compensation of agents in order to lessen their incentive to replace existing and adequate policies. I think the latest example that Senator Pryor just brought up will be addressed in these new requirements. Such practices as twisting, cold lead advertising, and high pressure tactics are specifically defined and prohibited as part of the sale of Medicare supplement insurance policies.

Senator ROCKEFELLER. How are they prohibited? By order of what and whom?

Ms. JENCKES. It will be through respective State laws or regulations. Some States can do it via the State insurance regulation; some States must do it by legislation. That is why it could take 18 months or 2 years, depending on how and when the legislators meet. But the effect is, in a relatively short period of time, as soon as that State can act, these prohibitions will be included.

In addition to these new requirements there are already in the statutes or regulations a number of other provisions. I would like to highlight that insurers are, in fact, required to meet loss ratio standards, involving the ratio of claim payments to premiums under existing—not future, but existing State regulation insurers who do not meet loss ratio requirements may be required to adjust their premiums downward to produce a loss ratio that meets that standard.

In closing, Mr. Chairman, I would just like to add that I do not think anyone cares about the Medicare consumer more than the insurance industry. We have been involved in attempting to offer a very fairly priced product and very carefully marketed product since, really, almost the inception of the Medicare program. Last year we were so concerned over some of the allegations that some abuses may still occur that we did our own survey. In fact, it was Tom Rice from the University of North Carolina that we commissioned to do the survey. We found that 90 percent of the beneficiaries were very satisfied with the benefits in their Medicare supplemental policies and 75 percent were very satisfied with the cost. We would be happy to share the results of that survey with the committee. We have a number of other consumer protection tools that we would also like to share with the committee, as well as the Buyers Guide. I would like to insert them for the record.

Thank you very much.

[The information appears in the appendix.]

Senator ROCKEFELLER. It will be done. Thank you, Ms. Jenckes.

[The prepared statement of Ms. Jenckes appears in the appendix.]

Senator ROCKEFELLER. Mr. Spielman.

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. SPIELMAN. Thank you very much, Mr. Chairman. I would ask that my full written statement become part of the record.

Senator ROCKEFELLER. It will be.

[The prepared statement of Mr. Spielman appears in the appendix.]

Mr. SPIELMAN. You have asked us to address two critical questions today. First: Why have Medigap premiums gone up? And second: Are the elderly getting a good buy on their Medigap insurance?

Medigap premiums generally have gone up for two reasons. First, the cost and utilization of Medicare covered services continues to increase. And second, the repeal of Medicare Catastrophic transferred a liability from the Government to beneficiaries and their insurers. Restoring catastrophic benefits to Medigap policies imposes new costs that in most cases must be reflected in higher premiums.

There are, however, many other factors that go into rate increases for a particular Medigap policy, such as the health needs of its enrolles—for example, one of our policies has an average age of enrollment of 80—geographic costs and utilization patterns, the adequacy of prior rates and loss ratios.

The importance of looking at the unique circumstances of each policy cannot be overemphasized. To assist the subcommittee in the review of this question we have included some estimates and survey data in our testimony. Averages, however, do not tell the whole story. But it was our opinion that they would be useful to you.

First, let me illustrate the typical effects of inflation and restoring catastrophic benefits on a hypothetical policy. These data do not relate to any particular policy but are in the ball park of our actuarial estimates. Attachment A to our written statement shows that two-thirds of every dollar of premium increase of this hypothetical policy is due to repeal—split about equally between the hospital and the skilled nursing facility copayment benefits.

Another one-third is due to cost and utilization trends. Thus, for a policy with a 30-percent increase in 1990, this means that 10 percent would be for inflation and 20 percent for benefit enhancements. For a policy costing $50 a month in 1989 experiencing these trends, this would mean that $5 more would be needed to cover inflation, $5 more for the hospital benefit and $5 more for the skilled nursing facility benefit enhancements for a 1990 premium of $65, without considering other factors.

Attachment B to our written statement specifically shows the results of our November survey. If Medicare Catastrophic had remained in effect, our plans were estimating a 9-percent increase—with repeal nearly a 30-percent increase.

The answer to your second question is: For those beneficiaries who have Blue Cross and Blue Shield Medigap coverage, yes, they are getting a good buy—a very good buy. We have consistently provided our subscribers with a solid benefit package, good service and high value for their premium dollar. However, Medigap insurance, even our own policies, is not a good buy for a beneficiary who owns several policies that provide the same coverage. Maintaining this multiple coverage is a waste of money.

Unfortunately, it is very difficult to get this message across. Speaking from my own experience, during the debate over repeal of Medicare Catastrophic, one of our own subscribers, a Federal retiree with Medicare coverage, called me to express her views about repeal. I am sure you have gotten some similar calls. In the course of the discussion she mentioned that in addition to her Blue Cross and Blue Shield and Medicare coverage she also owned three additional health insurance polices.

When I explained that the combination of Medicare and Blue Cross and Blue Shield together would cover virtually all of her acute care expenses she was not daunted. She quickly said, "But how do I know that the Federal Government won't take away my Medicare or take away my Federal employee's health benefits someday or cut my benefits?" I tried my best to assure her, but I am sure that right now she continues to have five policies—three of which she does not need.

While difficult, the best approach to this problem is through consumer education, beneficiary counseling and appropriate regulation of sales practices. The NAIC has recently undertaken a major new initiative in this area which you have heard about previously. Its new model Consumer Protection Standards, which are automatically incorporated by reference into the Federal Certification Program, require agents and insurers to ask about duplicative Medigap coverage. With certain limited exceptions, the sale of a second Medigap policy would be prohibited.

In response to Mr. Pomeroy's comments, we did support these changes.

Are all the policies available to the elderly a good buy? No. Some policies do not even pretend to be true Medigap policies; and some that do simply do not meet the minimum loss ratio standards. It is in this area where we believe the Federal Government could consider strengthening its review process to focus attention on the enforcement of loss ratio standards, not just the existence of standards. This approach, in our view, would not in any way supplant the appropriate role of the States in regulating Medigap insurance.

For 1990 we believe that the most important task is to make sure that the States update their laws and regulations to meet the NAIC standards and go about enforcing them. In the repeal legislation you gave States a year to adopt the new standards. We believe that the States will respond appropriately.

In conclusion, I want to reinforce our support for this subcommittee's efforts to rein in rapidly rising costs under Part B of Medicare. We are hopeful that the physician payment reforms enacted in November will lead to more appropriate medical practice patterns.

Containing Medicare cost growth helps beneficiaries directly in two ways—first, by moderating the growth in their Medicare Part B premium; and second, by moderating the growth in their Medigap premiums.

What can be done in the short term to minimize beneficiaries' Medigap premiums? I think we all can do something. Medigap insurers need to be responsible in their requests for rate increases. States need to devote adequate resources to their rate review and loss ratio monitoring efforts. And beneficiaries should review their insurance coverage to see if they are paying for excessive, duplicative insurance and shop carefully when they buy a Medigap policy.

From a Federal perspective, the Congress could consider two things: First, supporting beneficiary education and counseling programs, such as the proposal being developed by Senator Pryor; and second, as indicated earlier, focusing attention on loss ratio enforcement in the Federal certification of State regulatory programs.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you very much, Mr. Spielman. Let me just ask you two questions. Does Blue Cross medically underwrite in your Medigap policies?

Mr. SPIELMAN. The vast majority of our enrollment, Mr. Chairman, is in open enrollment type situations. There are some cases where, due to competitive market consideration, there are health questionnaires. But medical underwriting in the sense of giving a unique individual a unique rate, no, we do not do that.

Senator ROCKEFELLER. What are the nature of the so-called questionnaires?

Mr. SPIELMAN. There would likely be a question asking about preexisting conditions and similar types of questions. I would be happy to share any of that with you.

Senator ROCKEFELLER. What would be the result from the information that would come in response to an answer about preexisting conditions?

Mr. SPIELMAN. In the minority of cases where we have that arrangement, and in the small minority of cases where it triggers something, those individuals would not be given the policy.

Senator ROCKEFELLER. The GAO testified earlier this morning that Blue Cross's Medigap premium this year is going up 38 percent and that for commercials the average was 20 percent. How does Blue Cross explain that?

Mr. SPIELMAN. Well, Mr. Chairman, the number is not 38 percent. In our testimony we indicate our survey result was a median of 29 percent.

Senator ROCKEFELLER. Well GAO testified at 38 percent.

Mr. SPIELMAN. I think they were probably adding two items that were not additive.

Senator ROCKEFELLER. Well then let's take the 29 percent. That is still 9 percent above commercials.

Mr. SPIELMAN. Right. First, let me just say these type of data do not lend themselves to precise comparison. Our survey data is median estimates based on 38 out of the 75 Blue Cross and Blue Shield plans. I understand the survey of commercial insurers was based on 20 policies. In addition, these are estimates. In many cases they had not filed rates. I believe as you begin to see actual rates, it will be better data.

Having said that, there may be several factors that work here. The majority of our policies do cover catastrophic skilled nursing facility co-payments. I do not know whether in the other group of surveyed commercial insurer policies they did. As I indicated earlier, that can cost significantly. Our actuarial estimates has that running from $2 to $8 a month to restore $74 per day copayment benefit after the twentieth day of skilled nursing facility care.

The other factor that needs to be looked at here is the adequacy or the size of the rate increases last year. Our rate increases were quite moderate. Overall our rate increase was about 8 percent and many of our products—over 20 of our products—actually reduced rates. I know in California they made an across-the-board $2 reduction. In Pennsylvania there also were reductions. It is, therefore, important to look at the base.

The base in 1989 for Blue Cross and Blue Shield was in no way inflated. I do not know whether any of the policies surveyed in the GAO report were or were not, but this could affect the comparison.

And finally, I would say one needs to look at the loss ratios. If you are an insurer with a 100-percent loss ratio as opposed to one with a lower loss ratio, you have a little less wiggle room to absorb additional costs in the coming year.

Senator ROCKEFELLER. Thank you.

Ms. Jenckes, can you describe the extent of medical underwriting in the Medigap market?

Ms. JENCKES. I would presume for the commercial insurance industry it is relatively widespread. That is something that most of our companies do use so that we can put the most appropriate price on the product reflecting that individual's set of circumstances—the age of the individual, health experience, area of the country and other factors.

Perhaps Bob would like to comment, from his perspective at Mutual of Omaha, as one who does actually price the products.

Senator ROCKEFELLER. Okay. Mr. Shapland.

Mr. SHAPLAND. I guess I would speak based on knowledge about my own company. We have health underwriting questions and while we do not charge a higher price for people that have health conditions versus those who have none, we do reject the most severe health conditions.

Senator ROCKEFELLER. I am afraid I missed that last point. You do reject what?

Mr. SHAPLAND. We reject the most severe health conditions. But other than the very severe health conditions, we cover most people and everybody pays the same price. So, if you have some moderate health conditions we will sell you the policy at the same price as a healthy person.

Senator ROCKEFELLER. There is a lot of concern—and I am sure that Senator Pryor and Senator Durenberger would agree with this—about this whole concept of medical underwriting.

If for some reason or another, let's say, the Federal Government or State law or some magic wand were to prohibit medical underwriting would insurance companies be able to adjust to that?

Mr. SHAPLAND. I would like to respond to that question and say, obviously to the degree that that brought in worse risks we could raise our prices to accomplish that. I would think that there is a danger in this process in gaming, if you want to call it gaming. For example, I have heard stories—I do not know if they are true, but let's just make believe that they were—that some HMO's have open enrollment, but their open enrollment office is on the third floor and if you cannot walk up three flights of stairs then you do not get to enroll in their open enrollment program.

So by marketing techniques you can avoid some of the poorer risks and companies could game the system that way and get a competitive rate. So I think that while the goal is laudable, I think the real solution is the HIAA solution, and that is to have pools where we all share fairly in these poor risks and poor risks can buy coverages like everybody else.

Ms. **Jenckes**. I would like to address, Mr. Chairman, just the question of preexisting conditions. As you know, our industry has been hard at work trying to address the whole problem of how we can increase coverage as it relates to the under 65 population. Just recently our board of directors did approve some market reform recommendations which would include eliminating preexisting conditions for an individual once they are originally into the insurance system, which is the same requirement, if you will, that was approved for Medicare supplemental beneficiaries.

Senator **Rockefeller**. You mean once somebody had been entered into the system, a subsequent preexisting condition would not count. But it would at the point of entry?

Ms. **Jenckes**. Correct. You only have to satisfy the preexisting condition once. So if you move employment and, therefore, had a new insurance company or conversely if you're a Medicare supplemental beneficiary and you changed insurers from Mutual of Omaha, let's say to Prudential, you do not have to satisfy a preexisting condition again.

Senator **Rockefeller**. Thank you.

Senator Durenberger.

Senator **Durenberger**. Thank you, Mr. Chairman.

I want to go back to where I was in my opening statement, if I can. I really appreciate your testimony and the responsiveness to the Chairman's question. But I think, since the three of us are 20 percent of the Pepper Commission—we really have to deal with this issue of whether it is a good buy or not. Because the realities are that there are a lot of pressure to either go to Canada or Massachusetts to run our payment systems in this country. That means a single payer like Medicare or maybe two payers—Medicare, plus the States—until the employers and the rest of you die out of the system. Then we will have maybe States doing it. Then we will look like Canada.

So what we are talking about here is the realities that are pushing us to react to the public in the direction of a single payer of some kind versus multiple payers. I raised the question about—and we have all raised the question about the underwriting and the medically uninsurable and so forth, because we get the response which we just got from Mutual of Omaha and from others, that if we have to take the difficult to insure we are going to raise the prices for everybody.

That means the market is not working out there. If you can get away with raising your prices, everybody else gets away with raising their prices, there is no competition out there between insurers. That means that the consumer does not know what they are buying. That is all I have heard for 2 hours here this morning. The consumer does not really know how to make decisions.

Unless you can put your competition at some level other than the benefit and the price associated with the benefit, I think we have problems. So that is why I asked the question in the beginning about, what do you do for these folks, other than recycle their money into some doctor's pocket or some hospital's pocket. You can talk about the HMOs having to walk up three flights, but your toughest competition is people who will actually manage a patient's care.

Now I would like to make that tough competition, but most buyers are not buying at that level. They are buying at the benefit level. Mr. Spielman points that out here, because he says, let's not have anymore of this Federal stuff like Ron Wyden is talking about. We have serious concerns with proposals to change the role of the Federal Government in this market to one of designing standardized benefit packages that insurers must offer to the elderly.

You had better know that there are a bunch of folks on the Pepper Commission doing that right now. Not necessarily because it is the thing we started out wanting to do, but because everything seems to be telling us that unless we move this up to the level of some kind of standardized benefit packages, we got all the problems we have been talking about all morning.

Mr. Spielman's testimony says, "Consumers have been well saved by worthwhile benefit innovations, such as health promotion plans, dental coverage, eye care." I think I covered some of that earlier when I said, what does this have to do with health insurance. I am sure it is wonderful if you are in the eyeglass business. I think it is wonderful if you are an optometrist or an opthamalogist, annoculist and the rest of this sort of thing to have third party coverage for things that people should pay for.

If you want to know why we are talking about standardized benefits at the Federal level, it is because 12 percent of our money is going into insurance premiums to buy doctors and hospitals who cost us, what, 11 percent, 10 percent. Does anybody know that figure? For example, the good buy—let's just on Medicare supplemental—all of the premium costs in America last year for Medicare supplement were how many dollars and of that how many dollars actually got to the doctors and the hospitals? Does anybody know that figure?

Mr. SHAPLAND. I would just make an educated guess of 80 percent.

Senator DURENBERGER. So there is a 20-percent gap that is overhead of some kind. Right? That is the figure I have heard from others too.

Mr. Spielman.

Mr. SPIELMAN. Senator, for our policies our loss ratios are consistently above 90 percent. Our share of the market is about $4 billion which is about 40 percent of the market. As a ballpark estimate, you can take about 90 to 95 percent of that in terms of our policies.

Senator DURENBERGER. But you see the response—and again, I am just talking about loud here—the response from the consumer out there is, if 20 percent of this is going into recycling this stuff, why don't I let the Government do it because I am informed the Government does it for 2 percent or 3 percent or Blue Cross does it for 7 or 8 percent or something like that.

So you need to understand that behind this hearing today is not just the concerns about—well, that we have been talking about, but a very deep concern that we cannot guarantee access to everybody in this system through the current system which takes 20 percent to recycle it.

Now, if for that 20 percent we got something in exchange for that, then maybe the 20 percent would not be so bad, which is why I was asking the questions about what do you get for the money besides the recycling of the money. What are you doing to leverage down the health care costs? What are you doing to leverage down provider payments? What are you doing to manage patient care? What are you doing to change people's attitudes about what kind of providers that they ought to use under certain circumstances?

You know, maybe we would be willing to pay 5 percent or 10 percent or 20 percent or something if we picked up our rewards some place else in this system. But I do not see that that is happening. Mr. Spielman goes on to say that if we tried to standardize benefits that would leave consumers with the mistaken impression that all Medigap insurance is alike. That is a statement of fact.

They compete at the benefit level. You know, you compare my benefit with your benefit right up front there in this advanced payment. You are not competing at the service level which is what people really ought to care about. I do not want to go to a doctor if I do not have to. I do not want to go to a hospital if I do not have to. I would like to stay healthy rather than get sick. You do not compete at that level. You do not compete at the service level.

Ms. **Jenckes**. Senator Durenberger, if we could start the whole system over——

Senator **Durenberger**. I am just doing this to get a response.

Ms. **Jenckes**. Sure. I mean the Medicare system since we are discussing supplementing in an already existing Medicare program—I guess if we could start over we would devise another way to do it. In terms of cost containment overall and access to coverage in the system, we are working on several proposals—which while I am not going to call them the magic bullet—are certainly a step in the right direction and would benefit people of all ages.

One that I mentioned before was the small group market reforms, to assure that everyone associated with the small group market place can, in fact, get coverage in this country. We have a series of other recommendations that I would like to share with you as well. Bob mentioned the fact that we have State risk pools for high risk individuals who cannot afford the coverage for very legitimate reasons. We support making them widely available and I am very pleased to say that 20 States have them today.

Then there is the concept that Alan talked about in terms of wellness and self-help and the commitment to that. Some of our premium charges do in fact reflect the fact that people may not smoke and are given discounts in that area. Probably one of the greatest immediate potentials for cost containment is the whole emphasis on managed care that our companies and the Blues are working on with some major clients. I think it offers considerable promise for the future, however, I do not think that any one of these ingredients alone is going to solve the problem. But taken together, they can make a difference.

Mr. **Spielman**. Senator, can I take a shot at that?

Senator **Durenberger**. Yes. I used your statement. Go ahead.

Mr. **Spielman**. With respect to cost containment, let me just give you some examples. We do have some plans in the Medigap market that are experimenting with the use of the PPO networks, identifying cost effective providers. And, indeed, the Department of Health and Human Services right now is looking at one of our programs and has built a major piece of its current budget initiative around it.

So I think it is a little unfair to say that there is no innovation there. Broader, if you go beyond the Medigap market, when you look out in the private sector and look at the selective contracting, the PPO arrangements that are in place, you will see that we have the largest national PPO network that significantly exceeds what is available in Medicare.

And finally, if you look at the whole movement in cost containment and Medicare towards practice guidelines and appropriateness review, well, the Blue Cross and Blue Shield Association has pioneered medical necessity guidelines and diagnostic imaging and other things.

So I think the "what are you doing?" is a bit of a red herring. I would immediately agree with you that it is not enough. There is no question in my mind that it is not enough and we all have to do more.

Getting to the specific point of Medigap standardization, we do feel pretty strongly about this. One can separate out, I think, standardization of Medigap benefits versus some of the other things you are talking about on a broader basis in the Pepper Commission where you are looking at trying to standardize certain insurance practices. With respect to Medigap benefits I think you have to consider that two out of three Medigap enrollees have a product from one of two companies. They are either with us or they are with Prudential AARP.

Now our plans typically may offer two or three options. So there is not an extensive array of options facing the individual who makes the most typical choice here.

Second, I would say that the marginal benefits we talk about in the testimony—the eyeglasses, the wellness programs represent a minuscule proportion of the overall Medigap premium. In fact, one of the major marketing objectives that we have had over the last year, particularly with the increase in Medicare beneficiary premiums required by the Catastrophic coverage legislation, was to do benefit enhancements that had only a minor, negligible impact on the premiums.

So the money is not going, in large part, to those items.

Senator DURENBERGER. Mr. Spielman, I need to interrupt you because others need to ask questions and I need to conclude this. I am doing this this morning because there is only a few of us that appreciate—particularly since the President the other night said he is finally going to make health care an issue—how far behind the eight ball we are and you are. We have to figure out how big that eight ball is and get on it.

I think standardized benefits are coming. I think the elimination of State mandates are coming, whether you like it or not. I think a lot of other things that Ron Wyden talked about and others are coming and they are coming fairly quickly. And if they do not come we are not going to be able to preserve the existing private market place of providers and insurers. I have to tell you from my experience with the rest of these folks, we are going to be going to

Canada; we are going to be going to Massachusetts, unless, you know, we deal with the heart of some of these problems.

What is it we are buying when we pay those premiums? And it isn't all on your side. I agree that Medicare ought to be restructured and Medicaid and a lot of other things, that we are all in this together. But my sense is, it is coming a lot sooner than you think and this is sort of like the tip of the iceberg here today.

Senator ROCKEFELLER. Senator Pryor.

Senator PRYOR. Mr. Chairman, I need only 60 seconds. I bet you think, and our colleagues, that I am a broken record. But I am really obsessed with the possible abuse of this thing.

I would just like to put in the record, Mr. Chairman, this ad is from the Seattle Times. I must say it is 2 years old. But insurance agents, guaranteed Medicare leads, $25 for in-house appointments or $12.50 leads. Then it goes on down here. It also—you will like this—it says, "overcomes legal obstacles and let's you zero in on hot leads for all your products." And this says, "Call Linda, 1-800-433-5575."

Ms. JENCKES. That was not me, Senator Pryor. [Laughter.]

Senator PRYOR. I am hoping it is not our Linda here today. [Laughter.]

This is what struck me and I was going to ask you that. By the way, I just called Linda at 1-800-433-5575. They are still in business and still operating. I want to thank you, Linda, what you said awhile ago about your cooperation. I am just thinking, maybe through the Postal Service we can enact legislation or actually expand on the existing Postal fraud legislation that is on the books to do something about these cold leads.

Mr. Chairman, I am sorry for being a one issue member here this morning. I thank you.

Senator ROCKEFELLER. You are a good member, no matter what the issue.

Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman.

When we came forward with catastrophic health insurance we obviously moved into a segment of the problem that was being addressed in the private sector. And then, of course, as we all know, we backtracked on that and put the responsibility at least for awhile back out there on the people and on the private sector to try to respond to as best it can.

I want to make several points about that. The first one I want to make is that I think it provides private sector insurers an opportunity or a window to try to be very responsive to that set of problems. I happen to agree with the view that it is a national problem of a scope that the Government ought to be, in effect, stepping into with an insurance coverage program, with whatever modifications, and I think at some point we will.

But I think the fact that we have backed out for now offers the private sector a chance to offer some real leadership. I do not suggest that you are not doing the best you can right now, but I would like to make two or three recommendations to you and requests to you.

I think it is important that the private sector insurance—the two majors (here today) and anybody else that is in the game—get together and provide a suggestion as to a uniform package of Medigap coverage that would be a core package of benefits that would be exactly the same among insurers. And anybody that wants to be in the business and bid on that package can do so and they can compete on price; they can compete on customer service. But, in fact, there would be agreed to uniformity as to what the bundle of protections would be, with no differences.

The differences lead, I think, inescapably to almost an impossible difficulty for seniors to measure and make sense of. Some seniors can do it, many cannot. I do not think that it is in anybody's interest to have it that way.

What I would like to ask—of both the Health Insurance Association of America, by itself, and hopefully in conjunction with Blue Cross and Blue Shield and the other major insurance providers, is that you sit down together and see if you cannot give us some recommendation; and, in fact, talk it out among yourselves and see if you cannot come up with a common definition.

I think you ought to go further than that. I think you ought to have a core package of Medigap benefits that is standard and uniform and that does not move around. And if you change it, then the core changes and everybody will bid on that core package. Then if you want to offer add on services of one kind or another, fine. I think those ought to be standardized and categorized so again there is some uniformity. That if one provider can provide that particular additional protection at a lower cost then so be it. That is the way our private system is supposed to work. They get the benefit of the larger amount of business and the consumer gets the benefit of a lower price, and yet still gets the same protection.

I think it is time to do that. I think you ought to do it as a good business practice. I think it is sensible. I think it is fair. I think it is what the country needs. You have an opportunity right now, in effect, to do that. Now, I do not know the difficulties with talking back and forth across the industry lines from company to company. But I would like to ask you, and will formally request, Mr. Chairman, that you produce such a standardized package for us. If you cannot, you can come back to us in say 3 or 4 or 5 weeks and say, we tried, we cannot do it. But I do not want to hear that answer because I think you can; I think you should.

I would like you to do that. Would you be prepared to make that effort?

Ms. JENCKES. Certainly.

[The information appears in the appendix.]

Mr. SHAPLAND. Could I respond to that just a minute? I think if you make a study you will find out that for all practical purposes you might already be there. That is because the NAIC in each State has minimum packages of benefits like those you are talking about—that is the minimum core policies that you can sell. And most insurance companies, while they might have some variations from that will probably include it in their overall marketing because they want to have the cheapest policy possible to reach the segment of the public that cannot afford——

Senator RIEGLE. Do you have it today? Can you give it to us now?

Ms. **Jenckes**. We do. Those are the requirements that the National Association of Insurance Commissioners did. I do have a copy of it.

Senator **Riegle**. All right. Now, why don't you run down through what constitutes the core package.

Ms. **Jenckes**. Well, in essence, the replaced benefits under Catastrophic would be the $592 deductible on an all or nothing basis. In other words, an insurer would have to cover all of it or none of it. Then you get the various co-payments for hospital days and that is the 16th through the 19th day.

Senator **Riegle**. Let me tell you what I want you to give the committee in a formal submission, and our health Subcommittee on the Uninsured is interested in this as well.

That is, I want you to take that core package and I want you to talk to the other insurers and I want to see if there is, in fact, agreement across all insurers. Are you asserting today that that is the case? That there is an exactly similar package being offered by a variety of insurers?

Ms. **Jenckes**. They can sell no lesser than, but there are some companies——

Senator **Riegle**. I know, but that is a side step. Is that package for sale with a price tag on it and do you have standard add-ons that are comparable and can be compared to what other companies offer for the same things, using the same language, the same manner of presentation—like we have in Truth in Lending, like we have in Truth in Packaging?

My impression is that we do not have that. Now you are saying we do have it.

Ms. **Jenckes**. Senator, we are very, very close to truth in lending. I mean it is required by law to have an outline of coverage in a buyer's guide. And on each of those items it says, Medicare pays, you pay, this policy pays.

Senator **Riegle**. No, but I am talking about having a standard package that all companies will offer that want to be in the business, that is precisely the same, where there is a price tag associated with it and shoppers can compare the price for the same level of protection.

My sense is that we do not have that. Now are you telling me that we do have that and that all the companies that are out there have, in fact, agreed to do that and there is that package today and it is available and people can get it and read it and see it?

Mr. **Shapland**. No, there is not that agreement.

Senator **Riegle**. I appreciate the answer.

Mr. **Shapland**. There is this minimum package and companies will either come close to it or—usually come very close to it, but not go exactly with that package.

Let me give you an example of what my company does to give you an example. There is no requirement in the minimum that you cover the co-insurance for the skilled nursing days. We just decided to put that in all our policies. Our calculations show that is a very, very minor cost. It would be sort of foolish not to just automatically offer it in a policy. It would not make much sense to offer it as an optional rider for example, because it would only cost a few pennies in premium which would not be a practical thing to do.

Which is, by the way, one of the problems in having a minimum package. There would be some minor benefit options like that that so it would not make sense——

Senator RIEGLE. But can't you folks get together? I mean, you are private-sector companies but you are in a public service business. Can't you get together and iron that out and offer a uniform package. If it has to be updated every year and changed with some modification, can't you do that? Can't you get together and do that?

I mean there is a lot of confusion out there and you are in a position to help eliminate a lot of that confusion and give people a chance to do some comparison shopping and get more for their money.

Mr. SHAPLAND. Again, I am not a lawyer but I am thinking it might be illegal to do that. But to have a law or something to do that——

Senator RIEGLE. When you get a request, as you are getting one now officially, from a member of this committee to provide that information, I think that gives you sufficient ground to sit down and talk to one another about doing it. I think it needs to be done.

Now if in doing it you end up in a hair pulling contest and you find that you cannot resolve these differences, then tell us that. I would hope that you would not come back with that answer. I think the public wants this and I think they have a right to have it. You folks are smart enough and have been in business long enough to figure out how to do it.

So I think it is time to do it.

Mr. SPIELMAN. Mr. Riegle, could I comment? Within the last year or so, since Medicare Catastrophic, the minimum standards have been raised. Blue Cross and Blue Shield policies traditionally were significantly above the minimum standards. I suspect we will still be. But to give you an example, it never used to be a requirement to fill the Medicare hospital deductible.

Now we have a minimum standard that says, either you fill it in total or you don't fill it at all. There used to be a standard that said that you didn't have to kick in coverage under Part B until a $200 deductible was met. That is down to $75. So you see the minimum standards go up. So I suspect once everyone implements the standards that are now in place post-Catastrophic, I believe you will see a lot more similarity between policies in various parts of the country. I think most people will be able to have access to a policy that meets the NAIC minimum standards.

I would caution you on one aspect of this issue. That is, the policies, even if you would make them into the same cookie cutter, are not alike. And to give you some specific examples——

Senator ROCKEFELLER. Try to do it briefly.

Mr. SPIELMAN. Yes. Blue Cross and Blue Shield traditionally has made it very easy for people to file claims with piggyback billing and having service centers in the downtown where people can file their claim. That is a service level that results in higher claims costs, and therefore higher premiums. So in effect if you get people focusing solely——

Senator RIEGLE. A good point.

Mr. **Spielman** [continuing]. And excessively just on the price you may end up having them buy a policy that later, when they have claims to file they will find that they were sorry they bought.

Senator **Riegle**. Yes. Consumers are pretty smart. If they can understand what it is that they are buying. If there is a major service difference, they are going to figure it out and word of mouth will pass that around. And if somebody has got ostensibly a lower cost for the same package of services and they can't deliver the service they are not going to hold customers very long. There will be a course of complaints.

The point is, we need to have some price and service competition. The way to get that is to have a standardized package. It is time you folks got together and agreed on one and put it out there. And beyond the core benefits, if you want to offer Tier 2, Tier 3, Tier 4, you have an obligation to sit down, work that out, offer that.

Then if there are people out in the industry who are the people who should not be in the industry and who are selling policies for things that people do not need and so forth, then they start to self-identify and we can get them, I hope, out of the game so they stop fleecing older people in this country in the guise of offering protection that people do not need or are not getting.

So it is profoundly in the interest of the serious health providers to have that kind of standardized approach where you can have head on competition on price and service and then the best company gets bigger and those that are not so good get smaller. But we can also start to flush the other people out of the game that should not even be out there.

So I would like you to do it and I hope you will be back in a matter of a few weeks and have something that is standardized to present to us.

Thank you, Mr. Chairman.

Senator **Rockefeller**. I thank all of you very much, and I guess we will be hearing from you.

Ms. **Jenckes**. Thank you, Mr. Chairman.

Senator **Rockefeller**. Gail Shearer, who is in policy analysis for Consumers Union is our next witness; along with Victor Hurst, who is member of the board of directors of AARP.

Gail, maybe we could lead with you.

STATEMENT OF GAIL E. SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. **Shearer**. Thank you, Senator.

Mr. Chairman and members of the subcommittee, Consumers Union appreciates the opportunity to present our views on the issue of private health insurance to supplement Medicare. The Federal Government has a special obligation to monitor the performance of this market since the design of its own Medicare program has in effect created it and because there is a great deal of confusion about where Medicare ends and private responsibility for health care costs begins.

Medigap premiums seem to increase regardless of whether Medicare benefits grow or shrink. This troubles consumers. We urge the Congress to use the window of opportunity it now has with the growth of the Medigap market after the repeal of the Catastrophic bill to both critically review and improve the performance of the Medigap market. True reform of this market would be an appropriate way to celebrate the twenty-fifth anniversary of the enactment of the Medicare program.

I would like to commend Senator Pryor and his co-sponsors for his farsighted proposal that would establish a grant program for health insurance counseling for the elderly. Belief in the importance of a fully-informed consumer is at the heart of Consumers Union's very existence. We believe that the proposed counseling program could go a long way toward not only benefiting individual consumers, but toward helping this market evolve into a more competitive market that serves consumers well.

I would also like to commend Congressman Wyden for his commitment to seeking comprehensive legislation that would result in a dramatically improved Medicare supplement insurance.

I would like to comment briefly on Senator Riegle's line of questioning regarding standardization. We do not have standardization today. There are three States that have true standardization—Massachusetts, Minnesota and Wisconsin. But the NAIC specifically rejected the standardization approach in December. We recommended it strongly to them last summer when they were revising their regulations but they specifically rejected it.

I would like to point out one specific area where there is really a problem because there is no standardization. Consumer Reports pointed this out last spring. The coverage of excess charges is defined in many, many different ways by different companies and it is virtually impossible for consumers to make an intelligent choice about what policies cover in the lines of excess charges.

In my testimony I plan to briefly describe the key abuses in the Medigap market and propose five recommendations for legislation to eliminate these abuses. The key areas of market failure are: First, consumer confusion about the hundreds of choices in this market place. Second, the purchase of duplicative, overlapping coverage, with the industry itself estimating that 15 percent of the elderly own two or more policies to supplement Medicare. Third, low value of policies with inordinate amounts of money being diverted to pay for administrative and marketing costs and profits. Fourth, the twisting of consumers from one policy to another. This practice has been driven by high first-year commissions. Fifth, deceptive lead card company practices—I am sorry Senator Pryor is not here—where lead card companies send mailings to senior citizens often using names that make the mailing appear to be official government business.

The NAIC should be commended for amending its model regulation. We welcome the changes, including the prohibition of preexisting conditions on replacement business, the prohibition of the sale of a policy if the purchaser's total coverage would exceed 100 percent of actual medical expenses, and finally, the encouragement of State counseling efforts.

The NAIC actions, however, will not solve the Medigap problems. There are uncertainties about whether States will enact the changes and there are substantial uncertainties about whether the regulations, as written, are enforceable and whether States will devote sufficient resources to enforcing them.

In addition, again, we regret that NAIC chose not to take steps to standardize the Medigap market. We continue to believe that consumers desire a meaningful range of choice in this market.

I will outline briefly the five key steps that we believe Congress should take. First, Congress should establish a grant program to encourage States to establish comprehensive counseling programs for health insurance for the elderly. Twelve States already have counseling programs that train volunteers to sit down with the elderly on a one-on-one basis, to counsel them about Medicare, private Medigap insurance and long-term care insurance. HICAP in California and SHIBA in other States have been extremely effective in eliminating duplicative coverage and advising senior citizens of their coverage and their choices.

The HICAP program, for example, estimates that by eliminating inappropriate coverage senior citizens have saved twice as much money as the program costs. Congress should encourage all the States to establish their own counseling programs.

Second, Congress should standardize the Medicare supplement insurance market. I would note again that the key States that have done this are Minnesota, Wisconsin and Massachusetts. Under standardization, the Government would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions.

Third, the sale of duplicative policies should be banned. Many consumers buy more than one Medigap policy or a combination of a Medigap policy, hospital indemnity policy, and dread disease policy, with the hopes of being assured of protection against uncovered health costs. Congress should end this waste of billions of dollars a year.

Fourth, the Congress should reform the Commission structure for the sale of Medicare supplement insurance.

And fifth, the States should be required to effectively enforce actual loss ratios. In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively.

Thank you.

Senator RIEGLE. Thank you. We will have some questions for you in a moment.

[The prepared statement of Ms. Shearer appears in the appendix.]

Senator RIEGLE. Mr. Hurst, we are pleased to have you today and we would like to hear from you at this time.

STATEMENT OF VICTOR HURST, Ph.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, CLEMSON, SC

Dr. HURST. Thank you, Senator Riegle.

I am Victor Hurst, an AARP volunteer from Clemson, SC, and a member of the board of directors of the American Association of

Retired Persons. I want to commend you for responding quickly to critical warning signs in our health care system in general and in the Medicare supplemental insurance market in particular by holding these hearings.

I shall stress three major issues with you today. First, immediate steps that are needed to constrain health care cost increases. Secondly, the importance of public information and education in guarding against market place abuses. And thirdly, the impact that traditional insurance practices, such as age rating and medical underwriting will have on the affordability and availability of Medigap insurance in the future.

The steep and persistent increases in Medicare supplement insurance premiums are a continuing source of anxiety for older Americans. With repeal of the Medicare Catastrophic Coverage Act older Americans are dependent on private supplemental insurance to fill the many gaps in Medicare. As premiums continue to rise faster than Social Security cost of living increases, Medicare supplemental insurance is becoming increasingly unaffordable for many older people.

Increases in supplemental insurance premiums reflect the overall growth in health care costs, and in particular, the growth in Medicare costs. This year the Part A deductible increased over 5 percent and preliminary data tells us that in 1989 the Part B program increased roughly 12 percent. In addition, cost trends for supplemental insurance policies often are higher than Medicare cost trends, in part because sicker individuals tend to buy more insurance.

In 1990 supplemental insurance policies bear, once again, the costs of long hospital stays and a number of other benefits that were provided in 1989 by the Catastrophic Coverage Act. In fact, estimates are that this repeal results in a premium increase of $4 to $6 per month over what was originally estimated. Insuring that Medicare beneficiaries receive a fair return on their insurance investment is a high priority in this era of rapidly increasing health care costs.

AARP supports vigorous enforcement of loss ratio standards to assure that all insurance companies pay a reasonable share of premiums back to their policyholders and benefits. Very important in this regard will be careful monitoring of actual loss ratios--data which must be reported on all policies beginning in 1990. Where loss ratios are found to fall short of the mark and where companies and States do not move immediately to bring policies into compliance with the 60 to 65 percent standard for individual policies and the 75-percent standard for group policies, Federal action will be essential and perhaps the only recourse.

AARP also believes that the Congress should review the adequacy of the current 60 to 65 percent loss ratio standard for individual policies. A General Accounting Office study that would reveal insurance companies' administrative costs and profits, along with a review of the efficiency and appropriateness of their sales, administration and distribution practices, would help provide the information necessary to evaluate the present standard.

Regulating insurance practices, however, will not address the fundamental reason for increasing premiums—rapidly rising health care costs. Unless this Nation can bring the cost of health care under control, more and more Americans, young and old, will be unable to afford health insurance to protect themselves from the risk of large health care costs.

Important to this cost containment strategy will be the assessment of the appropriateness and effectiveness of common medical practices, implementation of the physician payment reform package enacted last year and public education about health care costs that will help individuals understand why health care costs are out of control and what they, as consumers can do about it.

Let me turn now to consumer protection in the Medigap market. Marketing abuses such as duplication of coverage, unnecessary replacement of adequate coverage, high pressure sales tactics, misleading advertising and poor value products appear all too often.

The National Association of Insurance Commissioners has made major improvements in this area over the last several years. AARP strongly supported these reforms and we hope that they will significantly reduce the types of sales abuses that have occurred. We urge this committee to watch closely over the next several years to assess the adequacy of these reforms.

Consumer protection must also extend beyond these standards. Older consumers are confused about both their coverage under Medicare and about their supplemental insurance benefits. We believe that both Federal and State Governments must give far greater emphasis to providing consumers with better information about Medicare and available supplemental insurance coverage.

Over the long run, we urge this committee to be prepared to examine the appropriateness of age rating and medical underwriting. While these traditional insurance practices cannot be dismissed out of hand, they should not be allowed to segment the market in such a way that a growing number of people will be excluded from coverage because of health problems and inability to afford premiums for policies that set rates based on age.

In conclusion, it is particularly important to note that as long as Medicare contains significant limitations or coverage gaps, the public will continue to seek supplemental coverage. Accordingly, the Federal Government has an obligation to assure that affordable supplemental insurance coverage is available. Enforcing actual loss ratios and the new Consumer Protection Standards approved by the National Association of Insurance Commissioners are fundamental to this effort. Similarly, public education can help ensure that consumers can make informed judgments about the cost, quality and adequacy of their health care coverage.

A long range view of the Medigap insurance market place, however, requires going beyond these immediate steps to examine basic marketing practices. However, each of these steps, in the absence of efforts to control high health care costs, will have only a marginal impact.

AARP applauds the efforts of this committee to address the many factors which stand in the way of American's ability to obtain affordable, adequate health care. We look forward to continuing to work with you on Medicare supplemental insurance issues as well as ways to reduce health care costs.

Thank you.

[The prepared statement of Dr. Hurst appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Hurst.

I am a senior citizen in the rural parts of West Virginia and I want to buy Medigap insurance. I know that I need it—or I think that I need it. But I have all these different signals coming at me. How easy or how difficult is it for the average senior citizen, in fact, to make wise decisions about Medigap insurance?

Dr. HURST. It is not an easy situation. I have been faced with that myself. As has been said here before, it is very difficult to compare policies, one with the other. In our case we have an Association of people, a membership, who have a great deal of faith in the Association and, to a certain degree, they place their faith in what we think we are offering as a good product.

However, we tell our people that most people who do not qualify for Medicaid need a supplemental policy and they need it with a good company. We say there are several good companies out there. Now how you comparison shop is a problem; there is not enough standardization of terms. There is not enough standardization of many aspects of policies so it is really difficult for a person to comparison shop. I think very often they look at the price.

Ms. SHEARER. Senator Rockefeller, could I comment briefly?

Senator ROCKEFELLER. Yes. I want to follow up on that. I think that HIAA indicates that about 15 percent of Medigap policyholders, Dr. Hurst or Ms. Shearer, have multiple contracts.

Dr. HURST. Yes.

Senator ROCKEFELLER. Now why do they have them? How do they get to that situation? And what can be done to make it easier for them not to be in that situation if it is not desirable for them?

Dr. HURST. The reason they get to it is because as we get older—and I can speak from experience in that role—we become more cautious, we become more conservative and we are concerned that we do not want our children to have to pay for our expenses. Therefore, we look in every way that we can to not put that burden on our children, nor our grandchildren. And we think that by buying more insurance and covering ourselves more adequately we will assure ourselves of that protection.

Unfortunately, as has been brought out this morning, as we know, this is not true. We constantly counsel with our members that if you have Medicare and one good policy that is all you need.

I live in a retirement community and we have some people there with as many as eight policies—eight policies. And they come to me and ask what they should do. I am telling them, "Get rid of seven, but keep a good one." And I will not go any further than that because I am not in the business of selling insurance.

I think one of the answers—and we try to do this through our Health Advocacy Program and through our Chapters—is to educate people that multiple policies are not necessary, that the primary carrier pays and forget about the rest of it.

But I think the thing that bothers me most of all as a senior citizen is watching some well-known actor on television that I related to 30 years ago when he was a cowboy and I thought he was a great guy and he is telling me what I should buy in the form of insurance. It is amazing how many people fall for that sort of thing and insure themselves far more than is necessary.

Senator **Rockefeller**. Ms. Shearer, you talk about standardization and that sounds somewhat desirable. Do you have evidence that standardization of these policies leads, in fact, to less confusion, leads, in fact, to less duplication, and leads, in fact, to lower premiums?

Ms. **Shearer**. Well in the Massachusetts, the best evidence there is, if you look at the loss ratios of the key policies there, they are extremely high. There is some complication here because the key policy is Blue Cross and Blue Shield and it tends to have high loss ratios anyway.

One of the key reasons that I have supported standardization is because there is a network of consumer organizations around the country—in Minnesota, in Wisconsin, in Massachusetts—that have been advocates of standardization for a long time and I rely in large part on their judgment of how the market is working. I cannot give you any hard data though.

Senator **Rockefeller**. HHS has a toll-free line, I think, on Medigap policies. Do you have any knowledge of whether or not people use that line, call that line? What can be done? I mean, AARP, it seems to me would be an extraordinary network. Consumers Union would be another.

HHS has a hotline. Do you have any idea of whether it is being used?

Ms. **Shearer**. I tried it this summer just to see what would happen. The key thing that they provide is a handbook that explains Medicare and it explains what different Medigap policies cover. They do not really go into great detail. I do not know if it would work for them to go into great detail about what different policies provide.

The best thing that I have found is that these 12 States that have counseling programs, train volunteers to sit down and go through the specifics of Medicare coverage, that go through the individual policies that consumers have. The feedback that we have been getting from these programs has been extremely favorable in terms of how successful they have been at helping people understand what they need and what they have.

Senator **Rockefeller**. Final question to Dr. Hurst. Do you think that Medigap loss ratios ought to be not 60 percent, but ought to be 70 percent or some figure like that?

Dr. **Hurst**. Yes. I would not be in a position to say what they should be, but certainly 70 percent is not too much to ask.

Senator **Rockefeller**. And do you think the consequences, Ms. Shearer, would be that there would be far fewer in the business or, do you think, that there would be as many in the business doing a better job?

Ms. **Shearer**. Assuming that the higher loss ratios were effectively enforced, I think there would be a little bit of both. I think that some of the worst actors would have to drop out of the market and companies left in the market would have to perform better. It would be a combination of the two effects.

Senator **Rockefeller**. Senator Riegle.

Senator **Riegle**. Thank you, Mr. Chairman.

Let me ask you, Dr. Hurst, you offer a policy to members—is it Prudential that is the provider?

Dr. **Hurst**. Prudential, yes.

Senator **Riegle**. Now did you define for Prudential what you wanted to offer as a package or did they say to you, "look, here is a package that we are prepared to offer" and you accepted that?

How was it developed as to what was in and not in the package?

Dr. **Hurst**. I really cannot answer that correctly. I can get that information for you.

Senator **Riegle**. Let me just use that as a lead to what I really wanted to get to and that is this: AARP, of course, has then a package available to its members and there probably is some sensitivity to the degree to which you end up pushing that versus, you know, one that is provided by somebody else. And knowing the quality of organization AARP is, I know that there would be careful attention to that sensitivity.

I would like to ask you as an organization, however, separate and apart from what is available through you and through Prudential to respond to the same question that I asked others earlier to respond to. I would like you to come back to us with a recommendation as to what you think ought to be a core package of Medigap protections that should be available, if you will, on a standardized basis by anybody that wants to be in the business. And then if you could go further with respect to add-ons of additional tiers of coverage for some other things that might be outside the core, that would be helpful too.

I say that because I do not know whether that would differ in some respect from the package that Prudential offers through you—and it may very well. I would like you and your folks to take a fresh look at it and tell us, if you can, what you think ought to go in a core package of standardized Medigap protections.

And then I want to lay that beside, if you will, what we get from the others who have committed today to come in with such a thing to see if we cannot line it up and come up with something that looks like it would work.

Also, I would like to ask Ms. Shearer of Consumers Union to do the same thing. Do you feel able as a group to—you have argued for standardization for a long time and I agree with the concept. I think it would be helpful to us if you would do exactly the same piece of work. What do you think ought to go in a standard package. Give us that. And then also provide increments of add-ons that you think ought to be there that the people might select for themselves.

The whole idea here is to get to a point where people can make meaningful comparisons and they can price shop then. They can quality shop to see if there is a difference in the service relationships that others have mentioned. But I think if we cannot get this done, then you are going to end up with a situation where I think there are going to be a lot of extra dollars spent, and there is going to be a lot of needless confusion.

I actually think that this problem, the way it works today, creates health problems. I know senior citizens. I know them in my own family circle and beyond who get sick worrying about this. I mean it actually damages their health because they are afraid that they do not have sufficient health coverage. It is just one of those constant nagging worries that if they cannot get decent answers and they cannot feel that they are going to be able to take care of themselves if a serious illness strikes, that will wreck your health as fast as anything.

I have seen it happen. I mean people come up to me and start to talk about this and will burst into tears and will talk with the deepest kind of feeling about the anxiety they have and it is obviously hurting their health. So from the point of view of just decency and common sense and having a health nation, which we must have if we are going to do well as a country, we have to make sure that people have health protection and that they have the ability to make sensible choices. They shouldn't ought to be fleeced out of 5 cents by people that get into this business in a fast buck way.

I am offended too by these ads I see on television by somebody who may have been a media star a few years ago who gets on and promotes these policies. My sense for that is that people are probably not getting real value from money they spend for that kind of heavily promoted product.

So I want to see standardization. I want to see a standard package that has basic benefits that everybody should offer. Let's at least get on a level footing here so that people can make a choice. Then I think we start to put the light on the people in this business who are not out there to help people, who are out there, I think, probably earning large profits because they are preying on people's fears and anxieties and inability to figure out what the real facts are.

We should not have a single person in this country that has a shoe box of policies because they are frightened—whether it is people with eight, such as you have seen down in your citizen place, and I am sure there are probably people we could find in this country with dozens of policies that they have gotten in an attempt to try to feel like they have covered themselves sufficiently.

We can expect then a response, I take it, from each of you in terms of a suggestion as to a core package.

Ms. SHEARER. Certainly.

Dr. HURST. AARP will be glad to cooperate in any way that we can along these lines because a package is one thing and regulations and standards are something else. But I think we are in effect tending to talk about the same sort of thing. We will be glad to work with.

Ms. SHEARER. Yes, I would be delighted to, Senator Riegle.

[The information appears in the appendix.]

Senator RIEGLE. I appreciate that. I do not want to suggest that that is a cure all. I mean we have other problems that go way beyond this that we have been talking about today in terms of how we get in and control the costs, hold them down, and still provide the quality of service. There are a lot of other aspects of this. So the fact that I am hammering this one aspect is just a part of the problem. But this is a part that we can fix and there is just no reason now not to fix it.

Thank you.

Senator ROCKEFELLER. Thank you, Senator Riegle.

One final question of Ms. Shearer. You indicate that you would like to see some reform in the Commission structure for agents who sell Medigap. That is very attractive as a concept to me because the whole sense of preying upon people's fears is wrong and is troublesome.

On the other hand, one has to think about precedent. I am just wondering if you know of any instance where this has been done before. Let's say for fire insurance, home insurance, car insurance, life insurance. Would there be legal difficulties for doing it for one section of an insurance policy market as opposed to another?

Ms. SHEARER. The best precedent I can cite is the State of Minnesota which has leveled its Medigap Commission structure already. I am not familiar with other lines and what their Commission structure might be like.

Senator ROCKEFELLER. They have done it by State law?

Ms. SHEARER. Yes, that is right.

The NAIC did take steps——

Senator ROCKEFELLER. State law or by State regulation, do you know?

Ms. SHEARER. I cannot tell you.

Senator ROCKEFELLER. Okay.

Ms. SHEARER. I am not sure.

The NAIC did take steps to try to lessen the differential between the first year and later year commissions, but there is a loop hole in what they did. They have required that the first year commission can be no more than 200 percent of later year commissions and if a policy is replaced, the first year commission structure can apply if the replacing policy is substantially better than the old policy.

We have seen what a burden—how difficult it is for States to enforce their regulations already, just the lack of resources, the lack of actuaries. To me, this puts a very high burden on State Insurance Commissioners to enforce that requirement. We hope it works. We are not convinced it will work, but it is a shot at it.

Senator ROCKEFELLER. Thank you, both of you, and all the other panelists. It occurs to me that there is, in fact, a gathering storm out there. I think we saw the beginning of it in the rejection of the Catastrophic health insurance bill.

I feel good about the direction in which we are all moving. I think we are beginning to identify certain problems. I am finding some responsiveness on the part of the private sector, which I might not have expected to have found maybe 2 or 3 years ago. And I think, in fact, one of the—perhaps, the only benefit, I can think of—of the rejection of the Catastrophic health insurance bill during the course of this past year was that it enlightened a lot of people. They had to deal with what catastrophic health insurance was, what respite care was, what hospice care was, and what immunosuppressives are. And in a sense, I think it helped to move health care, as an issue, closer to the center stage.

It is curious to me that over the last year and a half we have done a lot less reading and hearing and watching on television about MX missiles. There is about $600-plus billion being spent on health care in this country now. Its been estimated that by the year 2000 we will be spending $1.5 trillion on health care.

Obviously, that is not sustainable; and even with that cost, 37 million Americans do not have any health insurance and long-term care is not available to most Americans. Senator Riegle was talking about the fear factor. When you get into long-term care you really have a fear factor. I think that, in itself, says something about the fall of the Catastrophic Health Care bill.

In any event, I thank you and I thank all previous witnesses for your patience and for your helpfulness.

[Whereupon, the hearing was adjourned at 1:28 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR LLOYD BENTSEN

Mr. Chairman, I am pleased that you are holding these hearings today on the subject of Medigap insurance. The recent repeal of the new benefits provided under the Medicare Catastrophic Coverage Act was to many of us a deep disappointment.

That's behind us now, but the repeal of the catastrophic benefits makes it especially important that we assess the ability of private "Medigap" insurance to provide necessary coverage to elderly and disabled Americans. While the counts are not definitive, the Congressional Budget Office has estimated that 11 million Medicare beneficiaries purchase private Medigap coverage. Another 3 to 5 million beneficiaries receive Medigap coverage through employer-based insurance.

I am particularly concerned because the repeal of catastrophic took place late last year, leaving very little time for insurers to make the necessary changes in Medigap policies for 1990, and I'm sure causing a great deal of confusion for beneficiaries.

An area of considerable attention is the rise in Medigap premiums for this year. It is unfortunate, but not unexpected, that part of these increases are a direct result of the repeal of catastrophic benefits. For example, the premium for one Blue Cross and Blue Shield plan, in my home state of Texas, will increase $225 in 1990, 39% above the 1989 premium. Of this annual increase, $96 (about 43 percent of the increase) is attributed to the costs of benefits that would have been provided under the Medicare catastrophic program. This may be toward the high end of the range of increases occurring across the country, but it is not unique.

We have a good cross-section of witnesses here today, some with background information on Medigap insurance, others representing the concerns of insurers and of beneficiaries. I look forward to hearing from them.

PREPARED STATEMENT OF VICTOR HURST

Mr. Chairman, members of the Subcommittee, I am Victor Hurst, from Clemson, South Carolina and a member of the Board of Directors of the American Association of Retired Persons. I want to thank you for responding quickly to the critical warning signals in our health care market in general and in the Medicare supplemental insurance market specifically, by holding these hearings. Undertaking a careful investigation of the reasons behind increasing Medigap costs, putting cost containment strategies into place, and seeking appropriate answers to marketplace questions that will shape the Medigap industry in future years are essential to keeping necessary Medicare supplemental insurance affordable to those who need it.

My testimony will focus on immediate steps that are needed to constrain health care cost increases, the importance of public information and education in guarding against marketplace abuses, and the impact that traditional insurance practices, such as age rating and medical underwriting, will have on the affordability and availability of Medigap insurance in the future.

INCREASING HEALTH CARE COSTS

The steep and persistent increases in Medicare supplemental premiums are a continuing source of anxiety for older Americans. With the repeal of the Medicare Catastrophic Coverage Act of 1988, older Americans are dependent on private supplemental insurance to fill the many gaps in Medicare. As premiums continue to rise faster than Social Security cost-of living increases, Medicare supplemental insurance is becoming increasingly unaffordable for many older people, especially those living on relatively fixed incomes.

Increases in supplemental insurance premiums reflect the overall growth in health care costs and, in particular, the growth in Medicare costs. The over 5 percent increase for 1990 in the Part A deductible directly increases the cost of most supplemental insurance policies. In addition, data for the first 10 months of 1989 show that Part B costs increased by about 12 percent over 1988 levels. Since supplemental policies pay a percentage of Part B allowable charges, these policies are subject to the same, or higher, cost trends than the Part B program. Cost trends for supplemental insurance policies often are higher than Medicare cost trends in part because "sicker" individuals tend to buy more insurance coverage than "healthier" individuals.

In 1990, supplemental insurance premiums also will go up because of the repeal of the Catastrophic Coverage Act. Supplemental insurance policies will bear once again the costs of long hospital stays, and in some cases long skilled nursing home stays, that were covered in 1989 by Medicare. Estimates are that the repeal of the Catastrophic Coverage Act will increase supplemental policy premiums by about $4.00 to $6.00 per month.

Medicare supplemental premium increases must be closely scrutinized to ensure that older people receive a fair return for their insurance investment. Past studies by the General Accounting Office have documented numerous instances where insurers have failed to meet minimum loss ratio standards, thereby offering poor value to their policy holders. AARP supports vigorous enforcement of loss ratio standards to assure that all insurance companies pay a reasonable share of premiums back to their policyholders as benefits.

In response to a requirement by the National Association of Insurance Commissioners (NAIC) companies are required to report their *actual* loss ratios beginning in 1990. Careful scrutiny of this data over the next two years is a must to ensure compliance. Where loss ratios are found to fall short of the mark, and where companies and states do not move immediately to bring the policies into compliance with the 60 percent to 65 percent loss ratio requirement for individual policies and 75 percent for group policies, then Federal action will be an essential—and perhaps only—recourse.

AARP also recommends that the Congress take a close look at the adequacy of the loss ratio requirement for individual policies that is currently in place. Because for many older Americans Medicare supplemental insurance is a necessity, the cost of coverage, its accessibility to consumers, and efficiency in the marketplace are all critical factors in determining whether administrative costs or profits are excessive. The Association believes that an examination by the General Accounting Office of insurance companies' current administrative costs and profits as well as the efficiency and appropriateness of the ways in which these companies sell, administer and distribute their policies should be undertaken promptly to assist the Congress in setting an appropriate minimum loss ratio for these policies.

Regulating insurance practices, however, will not address the fundamental reason for increasing premiums: rapidly rising health care costs. Between 1984 and 1989, Medicare Part B expenditures increased 90 percent, an average of 14 percent per year. The Part B premium for Medicare beneficiaries has increased 91 percent over the last five years. Unless this nation can bring the costs of health care under control, more and more Americans, young and old, will be unable to afford health insurance to protect themselves from the risk of large health care costs.

The Federal Government has a vital role to play in controlling health care costs. Perhaps most important is providing support for research to assess the appropriateness and effectiveness of common medical practices. Congress undertook this effort last year as part of its Physician Payment Reform package which was enacted as part of OBRA 1989. Although the short term effects of this effort may be small, over the longer run, the significant expansion of research into effectiveness and appropriateness of medical practices holds the promise to fundamentally improve the quality of medical care for all Americans while at the same time eliminating enormous waste in the health care system.

Public information and education about health care costs also is critical. Individuals must begin to understand why health care costs are out of control and what they, as consumers, can do to lower health care expenditures.

CONSUMER PROTECTION

Unfortunately, the sale of Medicare supplemental insurance has too often been associated with a number of marketing abuses: coverage, high pressure sales practices, misleading advertising, and poor value products. AARP has worked on both the Federal and state levels for the passage of laws and regulations to correct these abuses. We have seen some progress recently.

Two years ago in conjunction with the Catastrophic Coverage Act, Congress required that advertising for Medicare supplement insurance be filed with state insurance regulators, and extended the "free look" period for supplemental insurance purchasers. In these last two years, the NAIC has substantially improved its Model Act and Regulations for Medicare supplemental insurance. Among other reforms, the NAIC has:

- increased the minimum loss ratio for group-sponsored Medicare supplemental insurance sold through the mail from 60 percent to 75 percent;
- required insurers to meet actual as well as projected loss ratio standards;
- required increased reporting by insurers of financial results;
- required insurers to put in place procedures to avoid over insurance and duplication of coverage;
- prohibited exclusions for preexisting conditions when one Medicare supplement policy is replaced with another;
- required policies to be "guaranteed renewable;" and
- established limitations on compensation to insurance agents in order to reduce incentives to "churn" coverage.

AARP strongly supported these reforms, and we hope that they will significantly reduce the types of sales abuses that have historically occurred in this market. We would urge this Committee to watch closely over the next 2 to 5 years to assess the adequacy of these reforms.

CONSUMER EDUCATION AND COUNSELING

Unquestionably, older consumers are confused about both their coverage under Medicare and about their supplemental insurance benefits. Medicare is a very complex program. And, Medicare supplemental coverage can also be difficult to understand since it complements Medicare's complex benefit structure. We believe that both the Federal and state governments must give far greater emphasis to providing consumers with better information about both Medicare and available supplemental insurance coverage. The best method of controlling fraudulent marketing practices and other sales abuses is to provide purchasers with sufficient information to let them make informed decisions about their health care coverage.

Several states, including Washington, California, and North Carolina, have created programs in which trained volunteers provide information and assistance to older people with questions about health insurance. Such programs can provide older consumers with access to a knowledgeable, independent source of information about Medicare and supplemental insurance coverage. These programs can help consumers compare supplemental insurance options, to understand the terminology, conditions and limitations of insurance policies, and to better assess their real need for supplemental insurance protection. And, as interest in long term care insurance grows, consumer education and counselling programs could play an invaluable role in assisting older persons to understand this new—and complicated—insurance option.

AARP urges this committee to consider ways to create consumer education and counseling programs in all states. One option would be to work with state insurance and/or aging departments. The most important point is that extensive consumer education is the most effective mechanism to combat fraudulent and abusive marketing practices.

LONG TERM ISSUES FOR MEDIGAP

Current concerns about the supplemental insurance market focus on premium increases and marketing practices, but other issues will increasingly draw legislative and regulatory scrutiny in the future. As premiums for Medicare supplemental insurance rise, insurers are looking for ways to offer lower-priced coverage to select populations as a method of increasing market share. The use of such traditional insurance practices as health screening and demographic rating (i.e., rates based on age, and location within a state) are becoming more and more common. While these practices may be actuarially sound, the resulting market segmentation can give rise to many of the problems now found in other parts of the health insurance system. If these practices come to dominate the market place, we can expect that a growing number of people will be excluded from coverage because of health problems, and inability to afford premiums of policies that set rates based on age.

We are not here today to suggest that all these practices are necessarily inappropriate in this market or that they should all be eliminated. But what we are suggesting is that in addition to focusing on current abuses and needed reforms, Congress, as well as state legislative bodies, must address the future role of supplemental insurance and how the supplemental insurance market should operate. Older people view Medicare supplemental insurance as a necessity, and often make significant sacrifices to buy coverage. As long as Medicare contains significant limitations and coverage gaps, the public will continue to seek supplemental coverage. Accordingly we have an obligation to assure that affordable supplemental coverage is available.

CONCLUSION

In the absence of Medicare coverage of catastrophic health care costs, Medicare supplemental insurance will play a very important role in older Americans' ability to obtain adequate protection against increasing health care costs. AARP applauds your scrutiny of Medigap premium increases and consideration of improved standards that would protect consumers from excessive premiums as well as marketplace abuses. These are essential and immediate steps toward consumer protection.

We also encourage you to consider what the Medicare supplement insurance marketplace will look like in future years if market segmentation trends continue. Supplemental insurance will quickly become both unavailable and unaffordable for those who need it most, if we do not address these trends.

However, it is important to note that while the repeal of the Medicare Catastrophic Coverage Act is one component—and a significant one—of increasing Medicare supplement insurance rates that we are observing this year, and the aging of the population accounts for a small percentage of the increase, the upward spiral of health care costs overshadows both of these factors. Escalating costs, whether paid out-of-pocket or through insurance premiums, inevitably translate into insurmountable financial barriers to essential medical services, particularly for society's most vulnerable members. AARP applauds the efforts of this Committee and the Congress to address rising health care costs. We look forward to continuing to work with you on issues that relate specifically to Medicare supplement insurance as well as on the all-important issues of health care costs.

AARP,
March 26, 1990.

Hon. DONALD W. RIEGLE, JR.,
U.S. Senate,
Washington, DC.

Dear Senator Riegle: In response to your questions to the AARP witness, Victor Hurst, at the February 2, 1990 Senate Finance Committee hearing on Medicare Supplemental Insurance, I am writing to provide further information on two issues:

(1) the manner in which AARP determines what benefits to include in its Medigap policies offered to AARP members through the Prudential Insurance Company; and

(2) what could constitute an appropriate core package of Medigap benefits and what additional benefits should be made available.

Regarding the first issue, AARP provides the AARP Group Health Insurance Program for the purpose of making quality, reasonably priced health insurance products available to AARP members. AARP chose the Prudential Insurance Company of America through a competitive bidding process to provide insurance to the Group Health Insurance Program.

AARP and Prudential jointly determine the benefits offered through the Group Health Insurance Program. To determine which benefits are preferred, AARP members are polled about benefits—current benefits and those that might be offered in the future. They are given the opportunity to provide value judgments about coverage, taking into consideration benefit structure as well as price.

Final decisions about benefit design are made by the Trustees of the Group Health Insurance Program, who are all volunteer members of the AARP Board of Directors.

In response to your second question, AARP believes that bringing more standardization to the way insurers describe and present policy benefits in both advertising and policy forms would make policies easier to understand and to compare. Presently, policies use different terms to describe the same benefits (e.g., "balance billing" or "excess charges"). Further, a more uniform format for presenting benefits would permit consumers to make side-by-side comparisons of policy benefits. The recent improvements made by the NAIC to the outline of coverage are a good start, but more uniformity in advertising material such as descriptive brochures, would be helpful. AARP believes that standardizing language and format would make choices clearer to consumers without preventing insurers from developing coverage for new benefits such as home health care and preventive care.

CORE BENEFITS

In general, a consumer's best insurance buy is a small package which covers those benefits that have the greatest likelihood of being financially catastrophic. A risk of creating a core package of Medigap benefits is that the mandatory package will be expanded to include benefits that exceed what is truly necessary to provide protection against catastrophic expenses. Coverage of the Part B deductible, for example, offers a poor return on the premium dollar and dramatically drives up the cost of a policy.

In addition, a core package or core packages should not encourage such a wide array of options on basic elements (i.e., coverage of differing amounts of the hospital deductible) that these benefits begin to generate confusion.

AARP does not believe that rigid standardization of policies is appropriate. If, however, a standardized approach to a core package and optional additional benefits were adopted, we believe that the following structure of core and additional benefits should be considered:

To supplement Medicare Part A:

- Coverage for all hospitalization in a benefit period, after the Part A deductible.
- Coverage for the reasonable cost of the first three (3) pints of blood (unless replaced or reimbursed under Medicare Part B).
- Coverage for coinsurance for Medicare eligible skilled nursing facility expenses (days 21 through 100).

To supplement Medicare Part B:

- Coverage for coinsurance for Medicare-eligible medical expenses, after a deductible equal to the yearly Medicare Part B deductible.
- Coverage for the reasonable cost of the first three (3) pints of blood (unless replaced or reimbursed under Part A).

ADDITIONAL COVERAGES/BENEFITS

- Coverage for 100% of the Part A hospital deductible.
- Coverage for physician expenses which exceed Medicare allowable charges. Insurers should cover all extra charges up the limiting charge as established in the physician payment reform enacted as part of OBRA 1989.
- Coverage for prescription drugs, subject to reasonable cost-sharing and maximum coverage limits.[1]
- Coverage for short-term nursing home and home care benefits, subject to reasonable cost-sharing and maximum coverage limits.[1]
- Coverage for incidental expenses. All policies should be permitted to contain incidental services, such as private duty nursing and coverage in foreign countries. These benefits should be described in a separate section which is clearly labeled "incidental benefits." A limit on the amount of incidental expenses (e.g., 5 percent of premium) may be appropriate.
- Consumers continue to request coverage of the Part B deductible in Medigap policies, but because most Medicare beneficiaries reach the deductible, offering it in a policy often costs more than paying the $75.00 out-of-pocket. Insurers run a small risk when they cover benefits that have very predictable rates of utilization. As a result, covering the Part B deductible has the almost certain outcome of driving up a policy's loss ratio. One way to accommodate the wishes of consumers and at the same time keep this benefit from disproportionately inflating loss ratios would be to require that policies which include this option have a loss ratio of one to two points higher than policies without such coverage.

The Association looks forward to continuing to work with you to achieve adequate consumer protections in Medigap insurance policies. If you have any questions about this information or if we can provide further assistance, please do not hesitate to call Tricia Smith of our Federal Affairs Department/Health Team at 728-4841.

---

[1] Note: The appropriate structure of this coverage may differ for a variety of reasons, including whether the coverage is medically underwritten.

Sincerely,

Martin A. Corry, *Director, Federal Affairs.*

Prepared Statement of Linda Jenckes

Mr. Chairman and Members of the Subcommittee, I am Linda Jenckes, Vice President of Federal Affairs for the Health Insurance Association of America. I am accompanied here today by Robert Shapland, Vice President, Mutual of Omaha arid an actuary. The HIAA is the principal trade association for the commercial health insurance industry. Our 350 member companies write over 85 percent of the private health insurance available from commercial companies in this country. Sixty of our member companies underwrite Medicare supplemental policies and 10 of those companies write the majority of that business.

I am here today in response to your request for our views on why premiums for private Medicare supplement policies are increasing this year. Since the repeal by Congress of the Medicare catastrophic Coverage Act of 1988 is an important factor in premium calculations, I will comment on the effect that action is having in 1990.

We appreciate your interest in the effects that changes in Medicare have on senior citizens. When the Medicare catastrophic benefit was enacted, we received many inquiries from concerned senior citizens wanting to know how their benefits, taxes and Medicare supplement premiums would be affected. We are experiencing the same phenomenon again, now that the Act has been repealed. Our member companies are currently working with state insurance regulators to implement appropriate benefit and premium changes in their supplemental policies for 1990. We are committed to assuring a smooth transition for all Medicare beneficiaries.

MEDICARE SUPPLEMENT PREMIUMS

It is important to look at the magnitude of premium increases being proposed by Medicare supplement insurers before examining the specific elements that led to premium increases. In a January 8 statement before the Special Committee on Aging, the General Accounting Office reported on a premium increase survey it had just done of 20 of the largest Medicare supplement insurers. The GAO found that the average 1990 increase was 19.5 percent. The GAO also reported that, generally, the companies attribute about half of the increase to the repeal of catastrophic, which resulted in certain minimum benefits being added back into policies, and the other half to other factors such as rising health care costs, utilization trends and operating costs.

I should mention that, unlike the Blue Cross and Blue Shield Association, the Health Insurance Association of America is comprised of competing companies, and, therefore, does not gather data on existing or proposed health insurance premiums of our members. If we were to do so, it might be found a violation of the antitrust laws aimed at price fixing. However, I can say that, based upon the limited information we have about current premium increases, we believe the GAO survey presents a fair picture of what is occurring. It agrees with our prediction—made to the House Committee on Aging prior to repeal of catastrophic—that average increases would be in the range of 20 to 25 percent.

An explanation of the specific factors which led to premium increases follows.

Repeal of the Medicare Catastrophic Coverage Act

Due to the repeal of Catastrophic, in 1990 all Medicare supplement policies, in addition to the other benefits they provide, must now cover the following expenses that they would not have covered had Catastrophic remained in effect. Specifically:

Part A (Hospital Services)

- $592 inpatient hospital deductible—the minimum benefit standard requires that Medicare supplements must either cover this entire amount or not cover it at all;
- $148 a day for the 61st-90th inpatient hospital days per benefit period;
- $296 a day for the 91st-150th inpatient hospital days (if the insured chooses to use nonrenewable Medicare lifetime reserve days)
- upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of at least 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare up to a lifetime maximum benefit of an additional 365 days.

Part B (Physician Services)

- coverage of all coinsurance amounts (20 percent of Medicare approved charges) under Part B, regardless of hospital confinement, subject only to an annual deductible. (Had the catastrophic law remained in effect, the liability of beneficiaries and their Medicare supplement policies for copayments would have been limited to $1,370 in 1990.)

In addition to these benefit changes, the repeal also generated significant administrative costs for insurers because of the need to revise policies, file them for approval by state regulators and notify policyholders.

Many Medicare supplements provide broader coverage than the minimum required benefits. Optional benefits include out-of-hospital drugs, skilled nursing facility copayments, nursing home care not qualifying under Medicare, medical care outside of the U.S., and physician charges in excess of Medicare approved charge levels (balance billing). The costs of these optional benefits are also increasing. While the catastrophic program may have offset some of the cost of these benefits last year, their effect on premium must now be recalculated due to the repeal of the Catastrophic Act.

The Effect of Increasing Medical Costs on Medicare and Medicare Supplement Premiums

The majority of claims dollars paid out by Medicare supplemental insurers are for the 20 percent of Medicare-approved Part B charges which are the beneficiaries' responsibility to pay.

Due to rising physician fees, more services being provided the elderly, the higher cost of new technology and the fact many procedures which used to be done in hospitals are now done in doctors offices, Medicare Part B payments have grown from $13 billion in 1983 to $37 billion in 1989—a compounded rate of 16 percent a year. It is estimated that the rate of increase will continue in 1990, resulting in payments by Medicare of about $43 billion for seniors covered under Part B.

Because Medicare supplement policies cover the beneficiaries 20 percent copayment, we are experiencing similar increases in supplemental claims payments.

The cost per claim is not the only problem, the number of claims is also rising. We believe that the increasing volume of Part B claims received by Medicare and supplement insurers is due in part to the "debundling" of services by providers. Debundling, or increasing the volume of covered services per beneficiary, is one strategy some providers use to counter recent Federal restrictions and cutbacks in provider payments.

We also note that incentives built into the Medicare prospective payment system, by encouraging a shift away from inpatient hospital treatment to outpatient procedures, have had the effect of increasing beneficiaries and supplemental insurers costs. Because outpatient procedures are covered primarily by Part B, at 80 percent of Medicare's allowable fee versus 100 percent when done on hospitalized patients, this means that Medicare supplement policies must reimburse 20 percent of an increasing number of outpatient claims.

While many factors have caused claims costs to increase, cost increases for Medicare supplemental policies closely parallel increasing Part B costs to Medicare. We believe that only drastic nationwide solutions can effectively cope with rising expenditures for physician services. The Medicare Physician Payment Reforms enacted as part of the Omnibus Budget Reconciliation Act of 1989 may be a major step toward a solution for Medicare supplements.

Other Cost Factors

In considering 1990 premium increases, it is important also to understand that the underlying health care costs of the people insured by each company differ. Insurers must project future health care costs and the utilization of benefits by their policyholders into their premiums. Variables that must be considered include:

- the specific benefits provided in a policy;
- the age of the policyholders (there is a direct relationship between age and utilization of health care)
- the past claims experience for that policy;
- regional variations in health care costs which may affect a company's insured population; and
- a company's operating costs, including the way in which it markets it policies (i.e., through direct mail, agents, association or employer groups)

These variables can result in considerable differences in the premium charged. They are one reason why the GAO survey that I mentioned earlier showed that, of the 19 companies who are increasing their premiums, the amounts ranged from 5 to 51 percent.

REGULATION OF MEDICARE SUPPLEMENT INSURANCE

In turning to the subject of how Medicare supplements are regulated, I think the initial point I would like to make is that Medicare supplements are clearly the most highly regulated form of health insurance. The very complexity of the regulatory scheme was a major reason why, as Congress considered whether to repeal the catastrophic benefit, industry representatives were asked to work with congressional committees to assure a smooth regulatory transition. The HIAA also worked with the National Association of Insurance Commissioners and is now working with insurance department officials in each state to guarantee continuity of coverage for policy holders during the months following repeal.

Under the terms of catastrophic repeal, all Medicare supplemental policies must be amended, effective January 1, 1990, to eliminate any duplication with the revised Medicare benefits. Insurers must: 1) inform policyholders of the changes in Medicare and their supplement policies; 2) issue policy riders adjusting coverage to pick up costs formerly covered by catastrophic; and 3) commence rate adjustment proceedings with the state insurance departments in order to bring policyholders premiums in line with the revised benefits. These steps are required for all Medicare supplemental policies in force.

The catastrophic repeal legislation set forth steps to be taken by The National Association of Insurance Commissioners and by state insurance regulatory officials to assure a swift and efficient transition. The NAIC has met all of the deadlines for issuing transition guidelines and amending its model regulations for Medicare supplemental policies. States are now following the transition guidelines and are beginning the process of adopting the appropriate permanent statutory and regulatory changes needed for them to conform with the NAIC post-catastrophic model regulation.

Both the transition and permanent NAIC models contain important new provisions for the protection of consumers.

Under the transition requirements, for policies that were issued prior to January 1, 1989, insurers will restore those benefits that were previously deleted due to the MCCA. Policies issued after January 1, 1989, must include, as a minimum, the benefits set forth in the NAIC transition model. In addition, one of the provisions we cooperated in drafting requires insurance companies to offer former policyholders, who allowed their policies to lapse during 1989 and do not currently have coverage, the opportunity to "reinstitute" their old policies without any new waiting periods for preexisting conditions. Benefits and premiums will be set as though coverage had never lapsed and the coverage will be effective retroactive to January 1, 1990, with premiums due from that date.

Consumer Protection

As each state implements the NAIC revisions to its permanent Medicare supplement insurance regulations, the transition period in that state will come to an end. Once in effect, the revisions will afford consumers the following new protections:

- Individuals purchasing Medicare supplement insurance policies after the states implement the revisions cannot be canceled for any reason except for failure to pay the premiums or a material misrepresentation.
- People who have obtained coverage in group Medicare insurance policies issued after the effective dates of the revisions will no longer be subject to loss of coverage because their membership in that group ceases or the group policy itself terminates. They will be offered continuation of coverage through an individual policy.
- The number of Medicare supplement insurance policies that an individual may purchase or an agent and company may sell to an individual has been limited, in effect, to one.
- In order to assure that sales of duplicative Medicare supplement policies do not occur, insurance companies are required, annually, to review their records for persons who have more than one Medicare supplement policy and report their findings to the states.
- Replacement of existing Medicare supplement insurance coverage with a new policy of that type will still be a choice allowed consumers. However, existing state requirements involving extensive disclosure of the results of replacement will be supplemented by new requirements which:

  —Prohibit the new insurer from imposing any new preexisting condition limitations or waiting periods for similar benefits in the new policy, and

—Place limits on compensation of agents in order to lessen their incentive to replace existing adequate policies.

- Require insurance companies and agents when soliciting applications for Medicare supplement insurance policies to obtain additional information, concerning the applicants past and present health insurance coverage. This information will supplement insurance companies existing efforts to obtain necessary information which is used to evaluate a person's need for health care coverage.
- Insurers will be required, if they have not already done so, to establish written marketing procedures to assure regulators that both existing and new consumer protection requirements are complied with.
- Such practices as twisting, cold lead advertising, and high pressure tactics are specifically defined and prohibited as part of the sale of Medicare supplement insurance policies.

Importantly, these new consumer protection provisions are in addition to *existing* state regulations which:

- prescribe the minimum benefits that a Medicare supplement must provide,
- require that policies automatically adjust to changes in Medicare deductibles and copayments,
- specify the information that must be provided by an insurer or agent when a policy is sold or updated,
- prohibit certain types of policy limitations or exclusions, and
- require insurers to meet loss-ratio standards involving the ratio of claim payments to premiums.

Under existing state regulations, insurers who do not meet loss ratio requirements must adjust their premiums downward to produce a loss ratio that meets the minimum standard.

Appropriateness of State Regulation

I would also like to comment on the fact that your attention is occasionally drawn to the marketing of insurance to the elderly. While numerous Congressional hearings have shown that the problems addressed by the Social Security Disability Amendments of 1980 (Baucus Amendment) have continued to a limited degree, we believe these problems have been adequately addressed by the NAIC. One of the primary functions of state insurance departments is to protect the consumers from marketing abuse, and we think it appropriate that the occasional incidents of abuse that are reported be dealt with at that level. Let me assure you, Mr. Chairman, that the HIAA is committed to protecting the interests of consumers in the Medicare supplement market.

In our opinion, this is not an area where Congress needs to add more statutes to the law books. In addition to their broad authority to regulate insurance, and the protection in their Medicare supplement regulations, virtually every state has in effect the NAIC Unfair Method of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance statute. The Unfair Trade Practices Act addresses virtually every aspect of company and agent activity and prohibits practices such as providing false information or advertising, rebates, unfair discrimination, unfair claim settlement practices and other unfair methods of competition or deceptive acts or practices.

Insurance departments also have other sanction authority, such as the agent licensing laws which also enable states to issue fines, revoke licenses and publicize the results of disciplinary actions.

Insurance Agents

In closing, I would like to highlight the important role that professional health insurance agents play in selling and servicing Medicare supplemental policies.

Companies market their policies in a variety of ways, through association groups, by mail, and through insurance agents. As I mentioned earlier, where agents are used, the cost of compensating them is included in the price of policies. Because the cost of marketing and servicing group policies is lower than for individual policies, the states require a higher loss ratio for group than for individual business.

Because licensed agents help bring health insurance to millions of individuals young and old, their important role should not be misunderstood or underestimated. Agents can perform all of the following services for the elderly: explain Medicare's benefits, describe how policies will pay benefits, hand deliver policies, review options, answer questions, assist in claims filings, and help schedule medical Provider Review Organization reviews.

About a third of those seniors with private coverage in addition to Medicare have it provided by a former employer. Of those persons who have private coverage not obtained through a former employer, 45.1 percent purchased it through a group or association, 44.5 percent from insurance company or agent, 6.9 percent by mail, and 3.5 percent belong to an HMO.

The fact that approximately 5 million seniors turn to agents for advice on their health insurance needs is testimony to the value of the service they offer. Understanding the Medicare program and its benefits can be difficult and confusing. Beneficiaries in need of advice can call the regional Social Security Office, the local Medicare carrier or intermediary and the area senior's consumer hotline. Or, they can rely on their local licensed professional health insurance agent. Many of the elderly turn to the agent who has the training, time and answers to best help them. We believe that compensating agents for the role they play in creating access to insurance is an eminently worthwhile expense appropriately reflected in the cost of many Medicare supplement policies.

Mr. Chairman, we are pleased to have had the opportunity to appear before your subcommittee today. We know that you recognize the value of Medicare supplemental insurance in helping the elderly meet the substantial health care expenses that Medicare does not reimburse. We share your interest in seeing that supplemental policies continue to offer fairly priced, ethically marketed protection, and that our policyholders are satisfied with their coverage. In that regard, a survey that we commissioned last year showed that nearly 90 percent of owners report satisfaction with policy benefits, and almost three-quarters, with policy costs.

If you have questions, I will be glad to respond now or, where it might be necessary, submit information for the hearing record. Thank you.

GUIDE

To Health Insurance for People with Medicare

1990

Some Basic Things You Should Know

Hints on Shopping for Private Health Insurance

Types of Private Health Insurance

What Medicare Pays and Doesn't Pay

Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

IMPORTANT MESSAGE

THE MEDICARE PROGRAM HAS BEEN SIGNIFICANTLY CHANGED FOR 1990 AND THIS WILL AFFECT HOW YOUR PRIVATE HEALTH INSURANCE COVERAGE IS NOW COORDINATED WITH MEDICARE. YOUR MEDICARE BENEFITS WERE CHANGED AS OF JANUARY 1, 1990, AFTER CONGRESS VOTED IN LATE 1989 TO REPEAL MOST OF THE PROVISIONS OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (PUBLIC LAW 100-360). THE CATASTROPHIC LAW EXPANDED MEDICARE'S BENEFITS AND ADDED SOME NEW ONES. SOME OF THESE BENEFIT CHANGES WERE IMPLEMENTED IN 1989 AND OTHERS WERE TO HAVE TAKEN EFFECT IN 1990 AND SUBSEQUENT YEARS. THEY NOW HAVE BEEN CANCELLED ALONG WITH THE ASSOCIATED SURCHARGES ASSESSED BENEFICIARIES TO PAY FOR THEM. IN REPEALING THE ACT, CONGRESS RESTORED THE MEDICARE COVERAGE THAT WAS IN EFFECT PRIOR TO JANUARY 1, 1989 (SEE PAGES 17 THROUGH 30).

DUE TO THIS LATEST RESTRUCTURING OF MEDICARE COVERAGE IT IS EXPECTED THAT MEDICARE SUPPLEMENT INSURANCE (MEDIGAP) BENEFITS AND PREMIUMS WILL BE ADJUSTED ACCORDINGLY. CONSEQUENTLY, YOU SHOULD RE-EVALUATE YOUR INSURANCE NEEDS BASED ON YOUR PRESENT MEDICARE COVERAGE, FINANCES AND THE STATUS OF YOUR HEALTH. IF YOU DISCONTINUED YOUR MEDIGAP POLICY IN 1989 YOU MAY HAVE THE OPTION OF REINSTITUTING THAT COVERAGE WITHOUT PENALTY UNDER CERTAIN CIRCUMSTANCES (see page 5).

NOTICE

LISTED IN THE BACK OF THIS PAMPHLET ARE THE ADDRESSES AND TELEPHONE NUMBERS OF EACH OF THE STATE AGENCIES ON AGING AND THE STATE INSURANCE DEPARTMENTS. THEY ARE AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS YOU MAY HAVE ABOUT PRIVATE INSURANCE TO SUPPLEMENT MEDICARE, OR SO-CALLED "MEDIGAP POLICIES. SUSPECTED VIOLATIONS OF THE LAWS GOVERNING THE MARKETING OF THESE POLICIES SHOULD BE REPORTED TO YOUR STATE INSURANCE DEPARTMENT OR FEDERAL AUTHORITIES. THE FEDERAL TOLL-FREE TELEPHONE NUMBER FOR REGISTERING SUCH COMPLAINTS IS:

1-800-888-1998.

AFTER APRIL 30, 1990, CALL:

1-800-638-6833

1-800-492-6603 (In Maryland)

SOME BASIC THINGS YOU SHOULD KNOW--Medicare pays a large part of your health care expenses, but it does not pay them all. There are limits on Medicare payments for some covered medical services, supplies and equipment. You also must pay certain amounts called deductibles and co-payments.

There are some services which are not covered either by Medicare or most private insurance. For example:

- **Custodial care in a nursing** home, or any other setting, is not covered by Medicare or most private insurance policies on the market today (See page 15).
- **Medicare and most private health** insurance policies generally pay only a specified percent of the Medicare approved amount. You pay the rest, including any charges in excess of those approved by Medicare. To avoid excess charges, ask your doctors or medical suppliers whether they participate in Medicare or accept assignment of Medicare benefits. Those who accept assignment agree to submit claims directly to Medicare and to accept as payment in full no more than the Medicare-approved amount. Doctors and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Others may do so on a case-by-case basis (See page 28). All physicians and qualified laboratories must accept assignment for covered clinical diagnostic laboratory tests.

Insurance to supplement Medicare, commonly called "Medigap" insurance, is not sold or serviced by the Federal or State governments. Do not believe advertising or agents who suggest that Medicare supplement insurance is a government-sponsored program.

Before buying insurance to supplement Medicare, familiarize yourself with your Medicare benefits. Once you have a good understanding of them you will be better prepared to determine your health insurance needs. Pages 17 through 30 explain your Medicare coverage. Please review them carefully.

DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE? NOT EVERYONE DOES.

- **If you are a Medicare** beneficiary enrolled in a prepayment plan, such as a health maintenance organization (HMO) or competitive medical plan (CMP), which has a contract with Medicare, you may not need a Medicare supplement policy (See page 12).

- **Low-income people who are** eligible for Medicaid generally do not need additional insurance. Individuals who are eligible for regular Medicaid benefits qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care.

- **Limited financial assistance is** available through Medicaid for paying a share of acute care costs for certain low-income elderly and disabled

Medicare beneficiaries. If your annual income is below the national poverty level and you do not have access to many financial resources, you may qualify for government assistance in paying Medicare monthly premiums and at least some of the Medicare deductibles and co-payments. The national poverty income levels for 1990 will be announced in February 1990. In 1989 the limits were $5,980 for one person and $8,020 for a married couple. The maximum annual income for qualifying for assistance may vary by State. If you qualify, this financial assistance is available through your State's medical assistance (Medicaid) office. For further information contact your state or local social service agency and ask about the "Qualified Medicare Beneficiary" benefit.

- **Whether you need health** insurance to supplement Medicare is a matter you may want to discuss with someone you know who understands insurance and your financial situation. The best time to do this is before you reach age 65. Some State insurance departments offer health insurance counselling services. You may want to check to determine whether your State does.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop carefully before you buy. Policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage is costly and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other prepayment plan; or buying a Medicare supplement policy (See pages 9 through 16).

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally defined as those conditions for which medical advice was given or treatment was recommended by or received from a physician before the effective date of your coverage under an insurance policy.

Most State laws require Medicare supplement policies to cover preexisting conditions after the policy has been in effect for 6 months.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem.

Beware of Replacing Existing Coverage. Be suspicious of a suggestion that you give up your policy and buy a replacement.

The new policy may impose waiting periods or have exclusions or waiting periods for preexisting conditions. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid for a policy many years.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies pay less than the Medicare approved amount (or nothing) for hospital outpatient medical services or services in a doctor's office than they pay for the same services provided to a hospital inpatient.

Check Your Right to Renew. Beware of policies that let the company refuse to renew your policy on an individual basis except for failure to pay the required premiums. These policies provide the least permanent coverage.

Most policies cannot be canceled by the company unless all policies of that type are canceled in the State. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. This means that although your insurance premiums may be adjusted from time to time, the insurance company cannot cancel your coverage. Policies that can be renewed automatically offer added protection.

Reinstituting Medigap Coverage. If you formerly had coverage under a Medicare supplement policy but discontinued it during 1989, you may have the right to reinstitute that coverage. The new law which repealed the catastrophic coverage act directs that Medicare beneficiaries who had Medicare supplement policies in effect on December 31, 1988, and who terminated them during 1989 must be notified by their insurers that they have the right to reinstitute substantially equivalent coverage if they have not replaced the discontinued policy with another policy or if they are subject to a waiting period for pre-existing conditions under the new policy. The notice to the former policyholders must be sent to the last available address by January 30, 1990, and must offer the beneficiary at least a 60-day period in which to request reinstitution of coverage, which would be effective January 1, 1990. In reinstituting substantially equivalent coverage, the insurer must grant the beneficiary at least the same premium classification terms that would have applied had there been no break in coverage.

Be Aware That Policies to Supplement Medicare Are Neither Sold nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of State law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State insurance department or Federal authorities (see pages 31 to 34). This type of representation is a violation of Federal and State law.

It is also unlawful for a company or agent to falsely claim that a policy has been approved for sale in any State in which it has not received State approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your State. This is for your protection. Agents also must be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy by an agent who tells you that there is a limited enrollment period. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend or relative whose judgment you respect. Allow yourself time to think through your decision.

If You Decide To Buy, Complete the Application Carefully. Some companies ask for detailed medical information. If they do and you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

Look for an Outline of Coverage. You must be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash . . . pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without information, contact your State insurance department.

Check For a "Free-Look" Provision. Insurance companies are required to give you at least 30 days to review a Medicare supplement policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and you will be entitled to a refund of all premiums you paid. Contact your State insurance department if you encounter a problem in obtaining a refund.

For Your Protection

Federal criminal and civil penalties can be imposed against any company or agent who knowingly sells you a health insurance policy that substantially duplicates coverage you already have and which will not pay benefits if your medical expenses are covered by another insurance policy or Medicare. There are also penalties for claiming that a policy meets legal standards for Federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medicare supplement health insurance policy in a State in which it has not received State approval. It is also unlawful for a company or agent to suggest that they represent the Medicare program or any government agency. If you believe you have been the victim of these or any other illegal sales practices contact your State insurance department (see pages 31 to 34) or call the toll-free number maintained by the U.S. Department of Health and Human Services and listed in the front of this pamphlet.

You should also report the misuse by any individual or company of the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, and Health Care Financing Administration, or the names, letters, symbols or emblems of the programs of these agencies. Federal law prohibits the use of these agencies' and their programs' identifying marks and names or variations of them to falsely claim or suggest that they have approved, endorsed or authorized any item, including insurance policies.

TYPES OF PRIVATE HEALTH INSURANCE

Private health insurance is available through group and individual policies. It is offered by some companies through agents and by other companies directly through advertising media and mail. Coverage offered and their values differ widely among both group and individual policies.

Types of individual and group health insurance coverages:

- **Medicare Supplement Insurance**
  Generally pays some or all of Medicare's deductibles and co-payments. Some policies may also pay for limited health services not covered by Medicare. The National Association of Insurance Commissioners (NAIC) has revised its model regulation to include new standards for Medicare supplement policies. These new standards require that, as a minimum, Medicare supplement policies include the following benefits:

  Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount ($592 per benefit period in 1990).

  Coverage of Part A eligible expenses for hospitalization to the extent not paid by Medicare from the 61st through the 90th day in any Medicare benefit period ($148 a day in 1990).

  Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days ($296 for each lifetime reserve day used in 1990).

Upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

Coverage for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with Federal regulations.

Coverage for the co-payment amount (generally 20%) of Medicare eligible expenses under Part B after you pay the annual $75 Part B deductible.

To determine what minimum benefit standards are in effect in your State and whether they apply to your Medicare supplement policy, check with your State insurance department. A State may adopt minimum benefit standards that are more stringent than those in the NAIC model regulation, and they may or may not apply to your Medicare supplement policy, depending on when it was issued. Be aware, however, that these standards apply only to private policies meeting the definition of a "Medicare supplemental policy" under Federal law. That definition specifically excludes policies or plans of employers and labor organizations as well as limited benefit policies, some of which are discussed on pages 15 and 16.

Medicare pays only for services determined to be medically necessary and only the amount Medicare determines to be reasonable (See page 27). Most Medicare supplement policies do not pay for services Medicare finds unnecessary, and some may not pay for charges in excess of Medicare's approved amount.

- **Prepayment Plans**
  There may be one or more prepayment plans such as a health maintenance organization (HMO) or competitive medical plan (CMP) in your area which participate in the Medicare program. Prepayment plans both insure health care and provide health care services. People who join are required to receive health services directly from physicians and other providers affiliated with the plan, except in an emergency when services may be furnished outside of the plan. Medicare beneficiaries are eligible to enroll in a prepayment plan only if they reside in the plan's service area and are enrolled in Medicare Part B. If you enroll in a prepayment plan, Medicare pays the plan a fixed amount each month to provide you with all Medicare-approved services. You may be required to pay the plan a monthly premium that covers the cost of deductibles and co-payments that would be your responsibility under Medicare if you were not a member of a prepayment plan. However, depending on the plan, there may not be an extra premium and the plan may offer services beyond those covered by Medicare. Services are prepaid, so usually there are no claims forms to process. If you enroll in a prepayment plan you may not need Medicare supplement insurance.

Group insurance is available through employers and voluntary associations.

- **Employer Group Insurance**

  Many people are covered by a group plan while they are employed. If you have such coverage find out if it can be continued or converted to suitable individual coverage when you retire. Check the price and the benefits, including benefits for your spouse. Employer group insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or preexisting condition exclusions. Consult your employer for information about special Medicare "secondary payer" rules that apply to employer group coverage for people who continue to work after they reach age 65.

  If you are 65 or older and insured by an employer health plan either through your current employment or the current employment of a spouse of any age your employer plan is primary payer and Medicare is secondary payer if the employer has at least 20 employees. You have the choice of accepting or rejecting the employer plan. If you accept the employer plan it will be the primary payer of your hospital and medical bills and Medicare will be the secondary payer. This means that if the employer plan does not pay all of your expenses, Medicare may pay a portion of any unpaid charges for services covered by Medicare. If you do not accept your (or your spouse's) employer plan, Medicare will be the primary payer of any covered health services and supplies you receive. When Medicare is the primary payer, the employer plan is not permitted to pay supplemental benefits for Medicare-covered services. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Medicare is also secondary to employer plan coverage for certain persons under age 65 who are entitled to Medicare based on a disability (such as employees, employers, other self-employed individuals and members of their families) and are covered by the group plan of an employer that has at least 100 employees or which participates in a multiemployer plan that provides coverage for at least one employer with 100 or more employees. Disabled persons have the same option to accept or reject the employer plan as do persons age 65 or over.

- **Association Group Insurance**

Many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65. Beware of claims of low group rates because coverage under group policies may be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following types of coverage are generally limited in scope and are not substitutes for Medicare supplement insurance or prepayment plans.

- Nursing Home Insurance . . . is available to cover custodial care in a nursing home and intermediate care facility (ICF). Policies also are available to pay for care in a skilled nursing facility after your Medicare benefits run out (See page 22 for a explanation of the Medicare skilled nursing care benefit). Many new insurance products covering long-term care in a nursing home have been introduced in the last few years. Some of these policies include coverage for in-home care beyond that which Medicare provides under the home health benefit.

  If you are in the market for nursing home insurance be sure you know which types of nursing homes and services are covered by the different policies available, by Medicare, and by any private insurance you may have. If you purchase nursing home or long-term care insurance (or have existing nursing home coverage) make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any prepayment plan or other coverage you have.

  As you assess your need for nursing home insurance, keep in mind that custodial care in a nursing home is not covered by Medicare or most Medicare supplement policies. The majority of persons in nursing homes receive custodial care. The only care in nursing homes that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a SNF. Policies that cover care in a SNF usually pay only the co-payments associated with days of care for which Medicare pays. When Medicare stops paying benefits for SNF care because the patient no longer requires this level or intensity of care, private insurance may also stop paying. Check the policy for the terms of coverage.

- **Hospital Confinement Indemnity Coverage** . . . pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits.

- **Specified Disease Coverage....** (not available in some states) provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

WHAT MEDICARE PAYS AND DOESN'T PAY—Medicare is divided into two parts—hospital insurance (Part A) and supplementary medical insurance (Part B). Pages 18 to 24 describe Part A benefits and pages 24 through 27 describe Part B benefits.

Medicare does not pay the entire cost for all services covered by the program. You or your insurance company must pay certain deductibles and co-payments. A deductible is an initial dollar amount which Medicare does not pay. A co-payment is your share of expenses for covered services after you have paid the deductible.

The chart on pages 20 and 21 gives brief outlines of both Part A and Part B. Please refer to *The Medicare Handbook* or contact any Social Security office for more information. **The chart describes Medicare only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private coverage as described in this pamphlet.**

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

What Medicare Part A Pays

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, for medically necessary inpatient care in a skilled nursing facility, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80% of the approved cost for durable medical equipment supplied under the home health benefit.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room, unless medically necessary, or convenience items such as a telephone or television in your room. Nor does Part A cover the first 3 pints of blood you receive during a calendar year. You cannot, however, be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf or if you have met the Part B blood deductible for the calendar year. In fact, to the extent the blood deductible is met under one part of Medicare it does not have to be met under the other during the calendar year.

BENEFIT PERIODS

Medicare Part A benefits are paid on the basis of benefit periods except for the blood deductible, which is calculated on a calendar year basis. A benefit period begins the first day you receive Medicare covered service in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits (except for any lifetime reserve days used) are renewed. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care (See page 24).

INPATIENT HOSPITAL CARE

Part A pays for all covered services for the first 60 days of inpatient hospital care in a benefit period except for $592, which is the hospital deductible for 1990. For the next 30 days, Part A pays for all covered services except for $148 a day. Every person enrolled in Part A also has a lifetime reserve of 60 days for inpatient hospital care. These days may be used whenever more than 90 days of inpatient hospital care are needed in a benefit period. While reserve days are being used, Part A pays for all covered services except for $296 a day. Once used, reserve days are not renewable.

Because of the change in Medicare benefits in 1990, beneficiaries who were hospitalized and paid the Medicare hospital deductible in December of 1989 and were still in the hospital on January 1, 1990, will not be liable for a new hospital deductible until their next hospital admission with a new illness.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but $592	$592
	61st to 90th day	All but $148 a day	$148 a day
	91st to 150th day*	All but $296 a day	$296 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE. . In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $74 a day	$74 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
HOSPICE CARE Available to terminally ill	Up to 210 days if doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints per calendar year	For first 3 pints***

* 60 Reserve Days may be used only once: days used are not renewable.

** These figures are for 1990 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

(2) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Visits limited to medically necessary care	Full cost of services 80% of approved amount for durable medical equipment (after $75 deductible)	Nothing for services 20% of approved amount for durable medical equipment (after $75 deductible)
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved charges (after $75 deductible)	Subject to deductible plus 20% of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)***

* Once you have had $75 of expense for covered services in 1990, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 28.)

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

SKILLED NURSING FACILITY CARE

Part A can help pay for up to 100 days of extended care services in a skilled nursing facility (SNF) during a benefit period. All approved amounts for the first 20 days of care are fully paid by Medicare. All approved amounts for the next 80 days are paid by Medicare except for a daily co-payment which is the responsibility of the beneficiary. The daily co-payment in 1990 is $74. It is subject to change annually.

To qualify for Medicare coverage for SNF care you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. The admission generally must be within 30 days of your discharge from the hospital, your physician must certify that you need the care and it must be for the condition for which you were treated in the hospital.

A SNF is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital or an intermediate care facility (ICF). Medicare benefits are payable only if you require a skilled level of care and the care is provided in a SNF certified by Medicare. Many nursing homes in the United States are not SNFs and many SNFs are not certified by Medicare. Medicare will not pay for your stay in a SNF if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Because the three-day prior hospitalization requirement and the benefit-period system were not in effect in 1989, special rules apply to Medicare beneficiaries who received extended care services from a SNF from 1989 into 1990. They will not be required to meet the three-day prior hospitalization requirement until they have not received inpatient hospital or extended care services for 30 consecutive days. After that, they will have to meet the prior hospitalization requirement in order to quality for additional days of covered extended care services.

HOME HEALTH CARE

Part A pays the cost of medically necessary home health visits for homebound beneficiaries. Coverage includes the intermittent services of a skilled nurse, and the services of physical and speech therapists when furnished through a Medicare-certified home health agency. If you require any of these services and are confined to your home and are under the care of a physician, Part A can also cover reasonable and necessary part-time or intermittent home health aide and skilled nursing services, occupational therapy, medical social services, medical supplies and a portion of the cost of durable medical equipment provided under a plan of care established and periodically reviewed by a physician. Part A does not cover full-time nursing care, drugs, meals delivered to your home or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

HOSPICE CARE

Medicare beneficiaries certified as terminally ill may elect to receive hospice care under Part A in lieu of regular Medicare. Part A can pay for two 90-day hospice benefit periods and one 30-day period, for a total of 210 days of care.

Beneficiaries enrolled in a Medicare-certified hospice program receive medical and support services necessary for symptom management and pain relief. When these services are provided by a Medicare-certified facility, the coverage includes: physician services, nursing care. medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There is no deductible. Patients must pay only limited cost-sharing for outpatient drugs and inpatient respite care. In the event the patient requires medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

What Medicare Part B Pays.

Medicare Part B helps pay for physician and various other medical services and supplies. You are automatically enrolled in Part B when you enroll in Part A unless you state that you don't want it.

YOU DO NOT HAVE TO PURCHASE PART B BUT IT IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT

PAYS ABOUT 75 PERCENT OF THE ACTUAL COST. IF YOU DO NOT NOW HAVE PART B COVERAGE AND YOU WANT IT, YOU MAY ENROLL DURING THE GENERAL ENROLLMENT PERIOD FROM JANUARY 1 THROUGH MARCH 31 EACH YEAR. IT IS AVAILABLE TO YOU REGARDLESS OF WHETHER YOU QUALIFY FOR PART A. IF YOU ARE COVERED UNDER YOUR OR YOUR SPOUSE'S EMPLOYER GROUP HEALTH PLAN, YOU MAY ENROLL IN PART B WHEN THE EMPLOYMENT ON WHICH THIS COVERAGE IS BASED COMES TO AN END, OR WHEN THE PLAN IS TERMINATED, WHICHEVER OCCURS FIRST.

When you use your Part B benefits, you will be required to pay the first $75 (the annual deductible) of charges approved by Medicare. After that, Medicare Part B generally pays 80 percent and you pay 20 percent of the approved amount for covered services you receive the rest of the year.

SERVICES COVERED BY PART B

- Physicians' and surgeons' services no matter where you receive them . . . at home, in the doctor's office, in a clinic or hospital. Routine physical exams are not covered.

- Home health visits. If you do not have Medicare Part A, then Part B pays for medically necessary covered home health visits for patients that meet the qualifying criteria as set forth for Medicare coverage of home health services. You have no deductible or co-payment except for 20% of the cost of durable medical equipment supplied under the home health benefit.

- Physical therapy and speech pathology services in a doctor's office, as an out patient, or in your home.
- Outpatient prescription drugs furnished hospice enrollees, non-self administerable drugs which are provided incident to physician services and immunosuppressives provided during the first year after an organ transplant.
- Other medical services and supplies, including outpatient hospital services, X-rays and laboratory tests, certain ambulance services, and the purchase or rental of durable medical equipment, such as wheelchairs.

EXPENSES NOT COVERED BY MEDICARE--Medicare does not cover certain kinds of care, charges or supplies. Among them are:

- Private duty nursing.
- Skilled nursing home care costs beyond 100 days per benefit period.
- Custodial nursing home care.
- Intermediate nursing home care.
- Physician charges above Medicare's approved amount.
- Most outpatient prescription drugs.

- Care received outside the USA, except under limited circumstances in Canada and Mexico.
- Dental care or dentures, checkups, most routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

Part B will not pay for any services which Medicare does not consider medically necessary . . . nor will most insurance policies.

APPROVED AMOUNT

In deciding whether a charge is "reasonable," Medicare reviews each year the usual charges of doctors or suppliers for each covered service and the charges of other doctors and suppliers in the area for the same service. The amount approved in payment for a claim is often lower than the actual charge made by the doctor or supplier.

Many Medicare supplement insurance policies pay only the Medicare co-payment that you are responsible for; that is, 20% of Medicare's approved amount. You might not get 100% coverage for your Part B bills even if you have Medicare Part B and private insurance. Here's how that could happen:

Suppose your doctor charges you $400 for an operation. And suppose the amount Medicare has approved for that particular operation is $300. Assuming you have already met the annual $75 Part B deductible, Medicare would pay 80% of the $300 approved amount, or $240. Many insurance policies would pay your 20% share of the $300 approved amount, or $60. That would leave a balance of $100 that you would have to pay out of your own pocket. You can avoid having to pay more than the Medicare approved amount by using doctors and medical suppliers who accept assignment.

ASK ABOUT ASSIGNMENT AND PARTICIPATING DOCTORS OR SUPPLIERS

Because you can't tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your doctors or medical suppliers, such as laboratories and therapists, if they accept assignment of Medicare benefits. Assignment means that the doctor or supplier will accept Medicare's approved amount as full payment and cannot legally bill you for anything above that amount. All physicians and qualified laboratories must accept assignment for covered clinical diagnostic laboratory tests.

While some doctors and suppliers accept assignment on a case-by-case basis, others have agreed to participate in Medicare and accept assignment on all Medicare claims. Their names and addresses are listed in *The Medicare Participating Physician/ Supplier Directory* that is distributed to senior citizen organizations, all local Social Security and Railroad Retirement offices, all hospitals, and all State and area offices of The Administration on Aging. The directory may be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area (see the back of *The Medicare Handbook* for the list of carrier addresses), or you can call the carrier to find out which doctors and suppliers are participating.

PAYING FOR MEDICARE--Part A is financed through part of the Social Security (FICA) tax paid by all workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked a sufficient period of time in Federal, State, or local government employment to be insured. Some disabled persons who do not meet the age requirement of 65 may also qualify for benefits. If you do not meet the qualifications for premium-free Part A benefits and you are at least 65 years old, you may purchase the coverage. The monthly premium is $175 in 1990.

PART B MONTHLY PREMIUM

Part B is optional and is offered to all beneficiaries when they enroll in Part A. It also may be purchased by individuals who do not qualify for Part A. The monthly Part B premium is $28.60 in 1990.

FOR ADDITIONAL HELP

If you need additional help or advice on Medicare benefits or eligibility, contact your nearest Social Security office or the Medicare insurance carrier in your area.

For information on private insurance to supplement Medicare, check your State insurance department or State agency on aging. (See the lists in the back of this pamphlet.)

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State insurance department.

STATE INSURANCE DEPARTMENTS

Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

Alaska
Alaska Insurance Department
3601 C Street, Suite 740
Anchorage, AK 99503
(907) 562-3626

American Samoa
American Samoa Insurance
Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

Arizona
Arizona Insurance Department
Consumer Affairs and
Investigation Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Bldg.
12th and University Streets
Little Rock, AR 72204
(501) 371-1813

California
California Insurance Department
Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-233-9045

Colorado
Colorado Insurance Division
303 W. Colfax Avenue, 5th Floor
Denver, CO 80204
(303) 620-4300

Connecticut
Connecticut Insurance
Department
165 Capitol Avenue
State Office Building
Hartford, CT 06106
(203) 297-3800

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 736-4251

District of Columbia
District of Columbia Insurance
613 G Street, NW
Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

Florida
Florida Department of Insurance
State Capitol
Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll Free (Within State)
1-800-342-2762
(904) 488-0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr., Dr.
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

Guam
Guam Insurance Department
855 W. Marine Drive
P.O. Box 2796
Agana, Guam 96910
011-671/477-1040

Hawaii
Hawaii Department of Commerce
and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 548-5450

Idaho
Idaho Insurance Department
Public Service Department
500 S. 10th Street
Boise, ID 83720
(208) 334-3102

Illinois
Illinois Insurance Department
320 W. Washington Street
4th Floor
Springfield, Il 62767
(217) 782-4515

Indiana
Indiana Insurance Department
311 W. Washington Street
Suite 300
Indianapolis, IN 46204
(317) 232-2395

Iowa
Iowa Insurance Division
Lucas State Office Bldg.
E. 12th & Grand Sts.
6th Floor
Des Moines, IA 50319
(515) 281-5705

Kansas
Kansas Insurance Department
420 S W 9th Street
Topeka KS 66612
(913) 296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O Box 517
Frankfort KY 40602
(502) 564-3630

Louisiana
Louisiana Insurance Department
P O Box 94214
Baton Rouge LA 70804-9214
(504) 342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta ME 04333
(207) 582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore MD 21202-2272
(301) 333-2792

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston, MA 02114
(617) 727-7189

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Missouri
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO
65102-0690
(314) 751-2640

Montana
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena MT 59604
Toll-Free (Within State)
1-800-332-6148
(406) 444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

New Hampshire
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

New Jersey
New Jersey Insurance Department
20 W. State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

New Mexico
New Mexico Insurance
Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

New York
New York Insurance Department
160 W. Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll Free (Within State
outside of NYC)
1-800-342-3736

North Carolina
North Carolina Insurance
Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

North Dakota
North Dakota Insurance
Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
(614) 644-2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK
73152-3408
(405) 521-2828

Oregon
Oregon Department of
Insurance and Finance
Insurance Division/Consumer
Advocate
21 Labor and Industry Bldg.
Salem, OR 97310
(503) 378-4484

Pennsylvania
Pennsylvania Insurance
Department
1326 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street
Suite 233
Providence, RI 02903-4233
(401) 277-2223

South Carolina
South Carolina Insurance
Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

South Dakota
South Dakota Insurance
Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

Tennessee
Tennessee Department of
Commerce and Insurance
Policyholders Service Section
4th Floor
500 James Robertson Parkway
Nashville, TN 37243-0582
Toll-Free (Within State)
1-800-342-4029
(615) 741-4955

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Blvd.
Austin, TX 78701-1998
(512) 463-6501

Utah
Utah Insurance Department
Consumer Services
3110 State Office Bldg.
Salt Lake City, UT 84114
(801) 530-6400

Vermont
Vermont Department of Banking
and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

Virgin Islands
Virgin Islands Insurance
Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Washington
Washington Insurance
Department
Insurance Building AO21
Olympia, WA 98504-0321
Toll Free (Within State)
1-800-562-6900
(206) 753-7300

West Virginia
West Virginia Insurance
Department
2019 Washington Street, E
Charleston, WV 25305
(304) 348-3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
(608) 266-0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
(307) 777-7401

STATE AGENCIES ON AGING

The offices listed in this section are responsible for coordinating services for older Americans.

Alabama
Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll Free (Within State)
1-800-243-5463
(205) 242-5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

Arkansas
Division of Aging and Adult
Services
Donaghey Plaza South
Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

California
Department of Aging
1600 K Street
Sacramento, CA 95814
(916) 322-3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

Commonwealth of the Northern Mariana Islands
Department of Community and
Cultural Affairs
Civic Center
Commonwealth of the
Northern Mariana Islands
Saipan, CM 96950
(670) 234-6011

Connecticut
Department on Aging
175 Main Street
Hartford, CT 06106
Toll Free (Within State)
1-800-443-9946
(203) 566-7772

Delaware
Division of Aging
Department of Health and Social
Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

District of Columbia
Office on Aging
Executive Office of the Mayor
1424 K Street, NW
2nd Floor
Washington, DC 20005
(202) 724-5626
(202) 724-5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.I. 96941

Florida
Office of Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE
Room 632
Atlanta, GA 30309
(404) 894-5333

Guam
Division of Senior Citizens
Department of Public Health
and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-2942

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548-2593

Idaho
Office on Aging
Statehouse Room 114
Boise, ID 83720
(208) 334-3833

Illinois
Department on Aging
421 E. Capitol Avenue
Springfield, IL 62701
(217) 785-2870

Indiana
Department of Human Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

Iowa
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue
Des Moines, IA 50319
(515) 281-5187

Kansas
Department on Aging
122-S Docking State Office
Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

Kentucky
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

Louisiana
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

Maine
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289-3658

Maryland
State Agency on Aging
301 W. Preston Street
Baltimore, MD 21201
(301) 225-1102

Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll Free (Within State)
1-800-882-2003
(617) 727-7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

Minnesota
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul, MN 55155-3843
(612) 296-2770

Mississippi
Council on Aging
301 W. Pearl Street
Jackson, MS 39203-3092
Toll Free (Within State)
1-800-222-7622
(601) 949-2070

Missouri
Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102-0690
Toll Free (Within State)
1-800-235-5503

Montana
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444-5900

Nebraska
Department on Aging
Legal Services Developer
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

Nevada
Department of Human Resources
Division for Aging Services
505 E. King Street
Room 101
Carson City, NV 89710
(702) 885-4210

New Hampshire
Department of Health and
Human Services
Division of Elderly and Adult
Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4394

New Jersey
Department of Community Affairs
Division on Aging
S. Broad and Front Sts.
CN 807
Trenton, NJ 08625-0807
(609) 292-0920

New Mexico
Agency on Aging
La Villa Rivera Bldg.
4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll Free (Within State)
1-800-432-2080
(505) 827-7640

New York
State Office for the Aging
Agency Building
2 Empire State Plaza
Albany, NY 12223-0001
Toll Free (Within State)
1-800-342-9871
(518) 474-5731

North Carolina
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

Ohio
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

Oregon
Department of Human Resources
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll Free (Within State)
1-800-232-3020
(503) 378-4636

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

Tennessee
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444-2727

Utah
Division of Aging & Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

Virgin Islands
Department of Human Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-0930

Virginia
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll Free (Within State)
1-800-552-4464
(804) 225-2271

Washington
Aging & Adult Services
Administration
Department of Social & Health
Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll Free (Within State)
1-800-642-3671
(304) 348-3317

Wisconsin
Bureau on Aging
Department of Health & Social
Services
P.O. Box 7851
Madison, WI 53707
Toll Free (Within State)
1-800-242-1060
(608) 266-2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll Free (Within State)
1-800-442-2766
(307) 777-7986

POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

Does the policy cover:	**YES**	**NO**
Medicare Part A hospital deductible?	☐	☐
Medicare Part A hospital daily co-payments?	☐	☐
Hospital Care Beyond Medicare's limits	☐	☐
Medicare Part B annual deductible?	☐	☐
Medicare Part B co-payments?	☐	☐
Medicare blood deductibles?	☐	☐
Private hospital room?	☐	☐
Private hospital nurses?	☐	☐
Medical appliances such as eyeglasses and hearing aids?	☐	☐
Custodial nursing home care?	☐	☐
Is there a coordination of benefits provision?	☐	☐
Can the company cancel or non-renew the policy?	☐	☐
What are the policy limits for covered services?	—	—
What health conditions are excluded under the policy?	—	—
How often can the company raise the premium?	—	—
How long before existing health problems are covered?	—	—
Does the policy have a waiting period? How long?	—	—

Prepared Statement of Senator George J. Mitchell

Mr. Chairman, I commend you for scheduling this hearing today to examine Medigap insurance policies. As members of this committee we are all aware of the tremendous impact the enactment and eventual repeal of the Medicare Catastrophic Health Act has had on Medigap policies.

Those of us who worked diligently to craft the Medicare Catastrophic Health Act did so with the best of intentions. We wanted to design a Medicare benefit which would cover many of the gaps which existed under current law—gaps which were most often filled by Medigap policies. Our intention was to design an extended Medicare benefit which would provide full coverage for all Medicare beneficiaries—not just those who are financially able to buy supplemental insurance policies.

Because we ultimately failed in this effort, it is even more important that we closely examine the Medigap policies which are available now. We must make sure that the existing policies provide adequate benefits for the elderly. We must assure that beneficiaries are not misled in purchasing policies which may contain provisions which are unnecessary or which duplicate benefits covered by Medicare. And we must assure that the elderly are properly informed about what benefits they need to supplement Medicare following the repeal of Catastrophic coverage.

I am also concerned about the ability of elderly Medicare beneficiaries to afford Medigap policies in the wake of the repeal of the Medicare Catastrophic Health Act and in the face of ever increasing health care costs. We are seeing tremendous increases in premium costs for these policies. In Maine, Medigap premiums have increased 57% since the repeal of Catastrophic. Clearly we must examine the causes for these dramatic increases and work to control future increases in premiums.

We need to determine whether the existing Federal standards, the so-called "Baucus Amendments" still provide adequate guidelines for the regulation of Medigap policies. It may be time to readjust those guidelines—to consider increasing the loss ratio standards for all insurance policies.

I am particularly pleased to have Earl Pomeroy, President of the National Association of Insurance Commissioners, with us today. NAIC has been an important partner with the Federal government in working to assure the quality of Medigap policies available to the nation's Medicare beneficiaries.

I look forward to hearing from the distinguished witnesses scheduled to testify this morning. It will require the best efforts of all parties concerned, the Federal and state governments, the insurance industry, and consumer advocates, to assure that the nation's Medicare beneficiaries receive the highest quality Medigap coverage at the lowest possible cost.

Prepared Statement of Earl R. Pomeroy

INTRODUCTION

As President of the National Association of Insurance Commissioners (NAIC) and Insurance Commissioner of the State of North Dakota, thank you for inviting the NAIC to furnish information on Medicare supplement insurance. The NAIC represents its members who are the 50 insurance officials of each state, the District of Columbia, Guam, America Samoa, Puerto Rico and the Virgin Islands.

MEDICARE CATASTROPHIC COVERAGE ACT

Mr. Chairman, the Medicare Catastrophic Coverage Act of 1988 which was enacted on July 1 of that year significantly expanded medical benefits for Medicare recipients. This expansion of Medicare benefits resulted in insurers eliminating duplicate benefits from insurance policies which were sold to senior citizens to supplement Medicare. Many individuals thought that this reduction in benefits would decrease the premiums and it came as a surprise to them that premiums, on the average, did not go down. In fact, many premiums increased last year after passage of the Medicare Catastrophic Act due to factors other than reduction in benefits.

POST-CATASTROPHIC ACT

As you all are painfully aware, the Medicare Catastrophic Act was short lived. After Congress repealed the major benefits along with the Part B premium increase and the surcharge on income, the NAIC acted immediately to implement a Transition Rule and revised Medicare supplement insurance minimum standards. By December 7, 1989, the NAIC membership had adopted these revisions—one week before President Bush signed the legislation.

In addition to the minimum benefit changes which were necessitated by repeal, the NAIC adopted "Consumer Protection Amendments" designed to enhance protections currently afforded to consumers. The objective in developing these consumer protection measures was to address, in part, the confusion that exists when seniors attempt to sort out different options available to them to supplement Medicare, particularly after passage of the Medicare Catastrophic Act. Equally significant was the desire to eliminate "churning" or "twisting," that is, the inappropriate replacing of an existing policy with a new one.

These "Consumer Protection Amendments" become part of the criteria for certification by the Supplemental Health Insurance Panel (SHIP)[1] along with the minimum benefit standards. It is therefore expected that all states will adopt these consumer protections this year. Thus far seven states have adopted the new Transition Rule (Arkansas, Florida, Idaho, Iowa, Mississippi, Nebraska, Ohio, New Jersey, Oregon, Virginia and Wisconsin). Washington State has already finalized its revised regulation. All other states are currently in the process of implementing the revisions.

Repeal of the Medicare Catastrophic Act has made senior citizen decision making even more difficult with respect to Medicare supplement insurance. State insurance departments are receiving many calls as a result of repeal. The NAIC shares your concern that consumers experience difficulty in ascertaining which Medicare supplement coverage is sufficient to meet their needs. To assist in this process, the NAIC continues to develop a Buyer's Guide jointly with the Health Care Financing Administration (HCFA). The Guide must be delivered to all prospective purchasers of a Medicare supplement insurance policy.

We were just informed last week that HCFA budget cuts prevented the agency from providing copies to the state insurance departments as it has in the past. The NAIC will therefore supply copies to the State insurance departments for use in their consumer education efforts.

MEDICARE SUPPLEMENT INSURANCE PREMIUMS

This Subcommittee has inquired why Medicare supplement insurance premiums are increasing after repeal of the Catastrophic Act. It was understandable that many people anticipated premium decreases after passage of the Catastrophic Act last year. However, the addition of more costly benefits to the coverage (the Part A deductible and coverage for the coinsurance for the first 8 days of skilled nursing facility (SNF) care), along with the increase in utilization and increase in medical costs, caused premiums to increase slightly in many cases in 1989. Mr. Chairman, I obtained an independent actuarial opinion of one rate filing in my own state last year to verify whether that particular increase was justified. The opinion demonstrated the actuarial validity of that filing. I shared your concern last year, and I continue to do so.

Unfortunately in 1990 it is even more likely that premiums will increase because the benefits which were removed from the policies last year must now be restored to conform to repeal of the Medicare Catastrophic Act. Although it is very early in the year, it appears that premiums are increasing only slightly more than they did last year, despite the restoration of benefits.

The following benefits have been restored:

1. The portion that Medicare does not pay for Part A Medicare eligible expenses for hospitalization for the 61st through 90th day.
2. The portion that Medicare does not pay for Part A Medicare eligible expenses for daily hospital charges during the use of lifetime reserve days (60 nonrenewable days).
3. The portion that Medicare does not pay (90%) for Medicare Part A eligible expenses for hospitalization subject to an additional 365 days lifetime maximum.

In addition, according to the revised NAIC standards, all new policies must provide a $75 deductible on Part B (doctor bills) rather than the previously allowed deductible of up to $200. The new standards also subject companies to the potential of unlimited liability for the Part B coinsurance (20%) because prior to 1990, the coinsurance contribution was based on $5,000 of eligible expenses. That $5,000 was removed from the standard. It is these benefits that contribute to premium increases.

---

[1] The Supplemental Health Insurance Panel consists of 5 members appointed by the Secretary of Health and Human Services: Barbara Gagel (Dept. of Health and Human Services), chair; Insurance Commissioner Andrea "Andy" Bennett (Mont.) Insurance Commissioner David N. Levinson (Del.); and 2 vacant insurance commissioner positions.

This year my department is receiving filings reflecting 4 to 20 percent increases. The percentage attributable to the increase in the Part A deductible is estimated at 5 to 7 percent, while the additional increase is attributable to the claims experience of the group certificate holders.

The premiums in my neighboring state of South Dakota are up 5 to 25 percent. South Dakota estimates that an average increase of 15 percent is due solely to the additional benefits required because of repeal.

In the State of West Virginia, the increases are ranging from 12 to 20 percent. Similarly, in the State of Minnesota, premiums are on the rise 7.5 to 15 percent as a result of repeal. However, only 6 or 7 filings have been approved so far. A number are still pending.

Michigan reports that the increases which have been authorized in that state under the ceiling imposed legislatively are a 13 percent increase for the commercial insurers and a 20.3 percent increase for the Blue Cross/Blue Shield plans.

The States of Arkansas, California, Kansas, Illinois and New York report filings similar to those mentioned above. What is evident from the information reported to us are identifiable factors which are contributing to the rate increases:

1. Repeal of benefits formerly provided under the Medicare Catastrophic Act
2. The increase in the Part A deductible from $560 to $592 and "trending" [2] of the Part B costs
3. Prior claims experience

In addition to these factors, all states which were contacted reported that loss ratio experience plays a role in determining whether the requested rates are justifiable. As you probably are aware, two insurers in New Jersey were ordered to lower their rates by up to 25 percent. The two companies involved had charged premiums that allowed them to maintain a loss ratio less than the 65 percent minimum required by the State of New Jersey.

ARE THE ELDERLY GETTING A GOOD BUY?

This very difficult question which you pose is one which we believe has been answered, at least in part, by the Congress in its decision to repeal the increased Medicare benefits and restore them to the private marketplace. Because of the heightened confusion created by repeal, the NAIC and the insurance commissioners believe that the insurance-consuming public deserves assistance and protection in filling the gaps that have been recreated by repeal of the Medicare Catastrophic Act. That is why the NAIC developed its "Consumer Protection Amendments," (summary attached) prepared a Buyer's Guide for purchasers of Medicare supplement insurance, encouraged the development of seniors counseling programs and will be implementing guidelines to assist state insurance departments in reviewing loss ratios.

CONCLUSION

The NAIC shares your concern that the confusion caused by repeal of the Medicare Catastrophic Act and the increases in premiums should be addressed and monitored. The states have quickly acted to rectify the confusion and educate consumers about the impact of repeal. At the same time, however, they are responding to repeal by procedurally implementing the necessary statutory and regulatory revisions.

With regard to premiums, the increases are predictably falling into ranges which are justifiable based on the factors discussed above. The ranges are not varying as widely as they did last year, but large hikes are reportedly justified, primarily because of prior claims experience. I will continue to monitor the loss ratios required by law in my state and expect my fellow regulators to do the same.

This concludes our written statement, Mr. Chairman. I would be happy to answer any questions you may have.

Attachment.

SUMMARY OF CONSUMER PROTECTION AMENDMENTS

This is a brief summary of the "Consumer Protection Amendments" to the NAIC Medicare Supplement Insurance Minimum Standards Model Regulation which were adopted at the December 7, 1989, meeting. They are discussed in the order in which they appear in the Regulation.

---

[2] "Trending" is making projections based on utilization and inflation of medical costs.

1. Require Guaranteed Renewability (Section 8)

The amendments are designed to require all policies and certificates to be guaranteed renewable. However, a commissioner has the authority under the amendments to authorize a cancellation or nonrenewal for any reason other than nonpayment of premium or material misrepresentation.

The amendments require further that if a group policy is terminated and the policy is not replaced, the insurer must offer the certificate holders an individual policy. The individual has the choice of continuation of the same benefits in the old policy or the minimum benefit standards policy recommended by NAIC. If *membership* in a group is terminated, the amendments require the insurer to offer conversion or continuation.

Finally, if a group policy is terminated and the policy is replaced by another group policy purchased by the same policyholder, the new insurer must offer coverage to all persons covered under the old group policy on the date of termination. Coverage under the group may not be subject to any new preexisting conditions.

2. Limit Agent Commission Structure (Section 12)

The amendments to Section 12 provide a three-prong approach to agent commissions. First, a limit on the differential between the first and second year commissions is imposed. Commissions or other compensation in the first year may be no more than 200 percent of the commissions or other compensation paid in the second year.

Second, the commission paid in the subsequent (renewal) years must be the same as that provided in the second year. The subsequent years' commissions must continue for a reasonable number of renewal years, also. This means that an insurer may not stop paying renewal commissions after the third year, as an example.

Third, agents may not receive first commissions on a replacement policy, unless the replacement policy contains benefits which are clearly and substantially greater than the benefits under the replaced policy. Also, insurers must establish a method of determining which replacement sales qualify for the first year commissions. (See Section 16, Standards for Marketing.)

3. Require New Arrangement in Outline of Coverage (Section 13)

Amendments to Section 13 require the benefits in the Outline of Coverage to be arranged in two major categories: the minimum benefit standards and the "add-ons." The total premium for the policy must be placed in a certain location on the Outline also. The new arrangement is designed so that consumers will find it easier to compare the cost and coverages of the basic minimum benefits policy versus one which has additional features.

4. Require Additional Responsibilities of Agent and Company During Application Process (Section 14)

Section 14 creates new responsibilities for agents and companies. Questions concerning an applicant's existing coverage are required, as well as questions about the applicant's coverage by Medicare. These questions are intended to furnish information about whether the sale of a Medicare supplement policy is appropriate, given the individual's circumstances. The appropriateness of a recommended purchase is a new standard required in Section 17, discussed below.

In addition to the questions mentioned above, agents must list all health policies sold to the applicant in the last 5 years, indicating those still in force.

Agents must now sign the Notice which is to be delivered to the applicant informing the applicant that a replacement sale is involved.

5. Require Companies to Establish Marketing Procedures (Section 16)

Section 16 of the Regulation is a new provision which requires companies to establish standards for marketing and to establish auditable procedures for verifying compliance. In addition, twisting, high pressure tactics, and deceptive cold lead advertising are specifically prohibited.

6. Prohibit Sale of More Than One Policy Except Under Certain Circumstances; Appropriateness of Recommended Purchase (Section 17)

The new Section 17 requires agents to make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. It also prohibits the sale of more than one Medicare supplement policy. However, more than one policy is acceptable if, when combined with the individual's health coverage already in place, the additional policy insures no more than 100 percent of the individual's actual medical expenses covered under the combined policies.

7. Require Reporting of Multiple Policies (Section 18)

The new Section 18 requires companies to provide a list of all individuals (residents of the State) who have in force more than one Medicare supplement policy. This list must be provided to the State Insurance Department. The specific format is no delineated in the model, except to require policy and certificate number and date of issuance, grouped by individual policyholder.

8. Prohibit Preexisting Conditions in Replacement Policies (Section 19)

The new Section 19 prohibits any replacement policy, including replacements made by another company, from containing any new preexisting conditions, waiting periods, elimination periods and probationary periods.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good morning. Chairman Rockefeller, I would like to commend you for holding this very important hearing. We continue to face problems surrounding the affordability and marketing of Medigap insurance policies and I am pleased we are focusing much needed attention on this issue.

With the repeal of the Medicare Catastrophic Coverage Act, we are seeing skyrocketing cost increases for these types of policies. In Arkansas alone, premium price increases are averaging 11-25 percent, and one insurer has applied for a 45 percent increase. But beyond the price increases and despite all the Federal and State regulation we have in place, reports continue to abound on Medigap marketing abuses. These price increases and market abuses are symptoms of a larger problem: confusion surrounding consumers' choices about health insurance coverage.

During the debate leading to both enactment and repeal of the Medicare Catastrophic Coverage Act, it became abundantly clear that older Americans, and their families, are very confused about what is covered and not covered under Medicare. Beyond the complexities of Medicare and Medicaid, decision-making about private coverage is exceedingly difficult for most people. This mass confusion helps explain why we continue to find people with 5 to 10 Medigap policies that are over priced, over sold, and seldom used. Moreover, as more and more long-term care policies hit the market, the potential for even greater problems increases.

To address this issue, Senators Heinz, Baucus, Daschle and Kohl will join me in introducing the Health Insurance Counseling and Assistance Act of 1990. This Act will give states the ability to establish programs, which emphasize the use of trained volunteers, to provide objective health insurance counseling to older Americans. In a few states where this inexpensive program has been tried, one-on-one, face-to-face counseling has saved elderly consumers on fixed incomes great amounts of money by helping them through the maze of health care coverage. It is a concept endorsed by many irl the private insurance sector, the National Association of Insurance Commissioners, and consumer representatives.

All three cosponsors of my bill have played leadership roles on this issue and I look forward to working with them on this and other legislation. Senator Baucus, in particular, has been at the forefront of Medigap reforms for years and I know he is already considering options to strengthen the enforcement provisions of the now appropriately named "Baucus Amendments." A number of other Senators have expressed great interest in this bill and I expect to welcome them on board to this effort in the very near future.

I also would like to take this opportunity to applaud Congressman Wyden's ongoing efforts and commitment to address the complexities of the Medigap supplemental insurance market. I look forward to hearing his testimony today, and to working with him to overcome the many problems and confusion our older citizens face.

As Chairman of the Aging Committee, I plan to focus additional attention on the Medigap issue in upcoming hearings. One thing is clear, the Finance Committee and the Aging Committee will not be satisfied until we find a way to address and control these large premium price increases and continued marketing abuses.

We face and must address many critical issues related to the Medigap supplemental insurance market. I am pleased to join you, Chairman Rockefeller, in this important effort. I believe that the testimony from our witnesses today will help us to craft creative and responsive approaches to these problems.

PREPARED STATEMENT OF THOMAS RICE

Mr. Chairman and Members of the Committee: My name is Thomas Rice. I am an Associate Professor in the Department of Health Policy and Administration at the University of North Carolina School of Public Health.

I am very pleased to speak with you today about the market for Medigap insurance policies, an area in which I have conducted research for a number of years. As you know, most Medicare beneficiaries purchase some form of supplemental insurance to cover medical expenses that are not paid for by the Medicare program. Seventy-five percent of beneficiaries own such policies; when combined with Medicaid coverage for the low-income elderly, 82% have some form of supplemental coverage.[1] Unfortunately, though, the 18% of beneficiaries who lack supplementation are largely comprised of the most vulnerable of the elderly. The poor and near poor, those over age 80, and those in poor health are much more likely than their counterparts to lack any form of supplemental coverage—either private coverage or Medicaid.[2]

The repeal of the Medicare Catastrophic Coverage Act has once again made ownership of a Medigap policy an absolute necessity. Policies typically cover a number of expenses that are not paid by Medicare: the costs of hospital stays exceeding 60 days; the 20% coinsurance on Part B allowed charges; and the hospital deductible. Some also provide limited coverage for prescription drug expenses and non-assigned physician charges. Without coverage for long hospital stays and physician coinsurance expenses, an elderly person is at risk of incurring very high levels of out-of-pocket costs. In my opinion, a major problem with the Medigap market is that the people who are least able to afford large health care expenses are exactly those groups who, as just noted, are least likely to have coverage: the poor, the very old, and those in poor health. When asked why they have not purchased additional coverage, most beneficiaries state that they cannot afford it. The second most common reason listed—but mentioned by less than one-fourth of beneficiaries—is that Medicare coverage is sufficient.[3]

Furthermore, even among those people who own private insurance policies, these same subgroups appear to be further disadvantaged. Beneficiaries with lower incomes and education levels are least likely to choose policies that provide more comprehensive coverage,[4] and least likely to receive subsidized premiums through their former employers.[5]

Although I have not conducted research on the desirability of alternative strategies for addressing this problem, the Committee may wish to consider further increasing the number of disadvantaged elderly who have either public or private Medicare supplementation. One of the parts of "Catastrophic" that was not repealed, which requires states to pay the premiums, deductibles and coinsurance of qualified Medicare beneficiaries, is an excellent step, but it still does not provide coverage for individuals above the poverty line. Additional steps could include further increasing Medicaid eligibility to the near-poor elderly, or alternatively, providing subsidies or tax incentives to encourage the purchase of Medigap policies.

Thus far I have focused on inequities in the ownership of policies. Another pressing issue—and the primary focus of today's hearings—concerns the costs of these policies. As you know, Mr. Chairman, Medigap policy premiums have been rising as astronomical rates. *The New York Times* reported that premiums rose by average of 40% at the beginning of 1989,[6] just after the passage of "Catastrophic," and the press now reports that new increases of nearly 30% are expected now that the legislation has been repealed.[7] The problem is further aggregated by the rises in Medicare Part B premiums, which, for several years, have far exceeded the five or six percent annual increases in Social Security benefits.

Once again, I have not studied alternative proposals for improving the market. However, I do think that the Committee should give serious consideration to raising the loss ratio standards from their present 60% level to a higher level, such as 70%. A recent General Accounting Office study indicates that whereas some companies—notably, most Blue Cross-Blue Shield plans and the Prudential-AARP Medigap policy—have been able to attain loss ratios in excess of 80%, the majority of others fall below 60%. Raising the minimum loss ratio should do one of two things: either make those companies with low ratios cut their premiums or reduce their costs (perhaps by paying agents on a different commission system), or drive them out of the market. In fact, research that I conducted with Nelda McCall and Arden Hall indicates that in the past loss ratio regulations appear to improve policy payouts.[8] Given the many hundreds of companies that sell Medigap policies, I do not think that stricter loss ratio standards would harm beneficiary access to the Medigap market.

Adding to the problem of premium increases are the difficulties consumers have in shopping for the most cost-effective policies. Although Medigap policies typically meet the Baucus minimum benefit standards, they vary so greatly in terms of additional benefits that they provide that comparison shopping is extremely difficult. Some of the features that vary among policies include: whether physician charges are based on the Medicare or private insurance fee; the extent (if any) to which prescription drugs are covered; and coverage for such things as preventive care, various long-term care services, and non-physician caregivers such as private duty nurses. Study after study has shown that consumers have very little understanding of the content of their Medigap policies.[9]

A proposed method of dealing with the difficulty of comparison shopping is to further standardize the market, perhaps by creating three or four classes of policies. This has been attempted in a few states—notably, Massachusetts, Minnesota, and Wisconsin. Standardization would make it easier to compare the premiums of policies in each class sold by different companies. I believe that the Committee should investigate such options, which could help consumers make better judgments about which policies are the best buys. However, any such regulations must be very carefully conceived so that they do not unduly reduce the ability of consumers to choose policies that best fit their needs.

Good consumer information is key to the functioning of any market. The two areas in which Medigap policy owners tend to show particularly low levels of understanding concern their liability for non-assigned charges, and coverage for nursing home care. The recent physician payment reform legislation, which this Committee was so instrumental in enacting, should dramatically improve consumer understanding of their liability for non-assigned charges, since it provides a clear maximum on the amount physician can "balance bill" beneficiaries.

Coverage for nursing home care, however, still presents tremendous confusion to beneficiaries. Although Medigap policies often purport to cover nursing home stays of up to 365 days in length, in fact this particular benefit is nearly worthless, because in most policies coverage is tied to Medicare coverage for skilled nursing care, which on average lasts only a few weeks.[10] In fact, Medigap insurance policies pay less than one percent of the elderly's total nursing home bill.[11]

I believe that the primary cause of consumer misinformation is not due to the private insurance industry, but rather, to the confusing nature of Medicare coverage for nursing home stays. Not only must stays meet specific requirements about prior hospitalization, but they must be in a particular type of nursing home (which doesn't exist in many parts of the country), and meet fuzzy restrictions regarding the necessity of "skilled care," often only for patients who have "rehabilitation potential." [12]

Elsewhere, I have argued that the most important step that Medicare could take in informing beneficiaries of their vulnerability to catastrophic nursing home costs would be to "eliminate the distinction between acute and long-term stays, and remove all of the other technicalities that prevent most stays from receiving coverage." [13] In other words, Medicare should cover a set number of days of nursing home care for all beneficiaries. One important consequence of this would be that Medigap policy coverage for nursing home stays would automatically become more comprehensible, since such coverage is linked to Medicare's. Only in this way would beneficiaries both know exactly what care is covered by Medicare and Medigap, allowing them to make a more informed choice about the need for long-term care insurance.

ENDNOTES

1. National Medical Expenditures Survey, Round 1: United States, 1987, National Center for Health Services Research and Health Care Technology Assessment. All estimates are preliminary and subject to change based on verification from subsequent rounds of data collection.

2. Christensen, Sandra, Stephen H. Long, and Jack Rodgers, "Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options," *The Milbank Quarterly* 65(3), 1987; Rice, Thomas, and Nelda McCall, "The Extent of Ownership and the Characteristics of Medicare Supplemental Policies," *Inquiry* 22(2), Summer 1985.

3. Rice and McCall (Note 2).

4. See: Cafferata, Gail, "Private Health Insurance Coverage of the Medicare population," Data Preview 18, National Health Care Expenditure survey, National Center for Health Services Research, DHHS Pub. No (PHS) 84-3362, 1984; and McCall, Nelda, Thomas Rice, and James Boismier, "Competitive Forces Driving

Medicare Utilization," Final Report, Health Care Financing Administration, Office of Research, February 1989.

5. Short, Pamela, and Alan Monheit, "Employers and Medicare as Partners in Financing Health Care for the Elderly," National Center for Health services Research, December 1987.

6. Tolchin, M., "Recipients of Medicare Also Face Rise in Cost of Private Insurance," *The New York Times*, February 12, 1989.

7. *Medicine and Health* 43(49), December 18, 1989.

8. McCall, Nelda, Thomas Rice, and Arden Hall, "The Effect of State Regulations on the Quality and Sale of Insurance Policies to Medicare Beneficiaries," *Journal of Health Politics, Policy, and Law* 12(1), Spring 1987.

9. For a review of this literature, see: McCall, Nelda, Thomas Rice, and Judith Sangl, "Consumer knowledge of Medicare and Supplemental Health Insurance Benefits," *Health Services Research* 20(6) February 1986, Part I.

10. Rice, Thomas, "The Use, Cost, and Economic Burden of Nursing Home Care in 1985," *Medical Care* 27(12), December 1989.

11. Waldo, Daniel R., and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," *Health Care Financing Review* 6(1), Fall 1984.

12. Rice, Thomas, and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," *Health Affairs* 5(3), Fall 1986.

13. Rice, Thomas, "An Economic Assessment of Health Care Coverage for the Elderly," *The Milbank Quarterly* 65(4), 1987, p. 517.

SUBMITTED BY SENATOR JOHN D. ROCKEFELLER IV

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

BACKGROUND INFORMATION ABOUT MEDIGAP INSURANCE

**Prepared at the Request of the
Subcommittee on Medicare and Long-Term Care
Senate Committee on Finance
U.S. Senate**

**Janet Lundy
Specialist in Social Legislation
Education and Public Welfare Division**

February 1, 1990

FOR COMMITTEE USE ONLY

CONTENTS

INTRODUCTION 1

MEDIGAP COVERAGE 2
Numbers and Percentages of Individuals with Medigap Coverage . . . 2
Characteristics of Those With Medigap Coverage 4
Numbers of Medigap Policies Purchased by Each Individual 5

MEDIGAP REGULATION, INCLUDING IMPACT OF P.L. 100-360 6
Standards in Effect Before 1989 6
Standards Created by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) 8
Standards Created by the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234) 12

MEDIGAP PREMIUMS 14
Medigap Premium Increases 14
Loss Ratio Standards 16

MEDIGAP BENEFITS 17

SALES PRACTICES BY THE MEDIGAP INDUSTRY 18

Acknowledgement: This document includes some material presented in the Congressional Research Service report entitled *Health Insurance That Supplements Medicare: Background Material and Data*. CRS Report for Congress No. 89-421 EPW, by Jennifer O'Sullivan and David Koitz. July 19, 1989.

BACKGROUND INFORMATION ABOUT MEDIGAP INSURANCE

INTRODUCTION

The term "Medigap" is commonly used to describe a private health insurance policy that is designed to supplement Medicare's coverage. Such policies pay for some or all of Medicare's deductibles and coinsurance amounts, and for 90 percent of the cost of 365 days of inpatient hospital care if Medicare's coverage has been exhausted. In addition, some Medigap policies cover services not covered by Medicare, such as prescription drugs. Medigap policies may be (1) provided by employers or former employers; (2) sold privately to individuals by commercial insurance companies or Blue Cross/Blue Shield plans; or (3) sold to individuals through groups such as organizations for the elderly.

Information and data concerning Medigap policies is sometimes confusing because of the use of the terms "Medicare supplement(al) health insurance" and "health insurance supplementary to Medicare." A "Medicare supplement(al)" policy is generally the same as a "Medigap" policy, i.e., a policy linked explicitly to Medicare's coverage and limitations. However, the term "health insurance supplementary to Medicare" is often used to describe any health insurance coverage a Medicare beneficiary may have, including a comprehensive major medical policy, coverage from a health maintenance organization (HMO), a hospital indemnity policy, a long-term care policy, a specified disease (e.g., cancer) policy, etc.

Federal legislation (primarily Section 1882 of the Social Security Act) includes provisions for regulation of Medigap policies, including (a) State adoption of standards developed by the National Association of Insurance Commissioners (NAIC), (b) a voluntary certification program of Medigap policies by the Department of Health and Human Services (DHHS), and (c) criminal penalties for certain abusive Medigap sales practices.

The remainder of this report provides information on coverage of individuals by Medigap policies; the regulation of Medigap policies, including the impact of the Medicare Catastrophic Coverage Act of 1988 and its repeal; Medigap premiums; Medigap benefits; and sales practices by the Medigap insurance industry.

MEDIGAP COVERAGE

There currently exists no survey that collects, on an ongoing basis, information about Medigap coverage. This report includes information from several studies that have been conducted in recent years. The studies mentioned here provide information on the aged Medicare population (age 65 and older), excluding Medicare beneficiaries under age 65 (disabled and others). The coverage data vary from study to study because of the varying definitions of Medigap coverage used and the nature of each study.

In general, one can conclude from these studies that approximately 70 to 80 percent of those with Medicare (approximately 20 million individuals) also have some other type of private health insurance coverage (not all of which is Medigap coverage). Approximately 40 percent of those with Medicare (about 11 million individuals) purchase private insurance coverage, most of which is probably Medigap coverage. Another 30 or 35 percent of Medicare beneficiaries (about 8 million) have employment-based coverage, less than half of which is probably Medigap coverage. Data from several studies follow.

Numbers and Percentages of Individuals with Medigap Coverage

Current Population Survey. The Current Population Survey (CPS) conducted by the Census Bureau collects, among other information, data on other health insurance coverage of the Medicare population. It is important to note that the survey does not collect information on Medigap coverage, but rather includes data on any type of health plan coverage that a Medicare beneficiary might have that is purchased privately by the beneficiary or is provided by an employer.

According to preliminary unpublished tables provided by the Congressional Budget Office (CBO), data from the March 1988 CPS show that, in 1987, approximately 71 percent of the noninstitutionalized Medicare population aged 65 and older (or 19.407 million beneficiaries) also had some type of private coverage either through individually purchased policies or through employment-based plans.

Approximately 41 percent of the noninstitutionalized aged Medicare population (11.325 million beneficiaries) had individually purchased, nonemployment-based coverage. Though the CBO analysis does not provide this data, it is reasonable to assume that most of this coverage is through Medigap policies. (Some individuals who had employment-based plans may have also purchased such nonemployment-based coverage, but this information is not included in the CBO numbers).[1]

---

[1] CBO's number of individuals with private, nonemployment-based coverage may be underestimated because individuals who had such coverage and employment-based coverage were recorded as having employment-based coverage only.

Approximately 29 percent of the noninstitutionalized aged Medicare population (8.082 million beneficiaries) had employment-based coverage. The CBO analysis does not provide information on the type of coverage, which could be a Medigap policy, a more comprehensive major medical policy, or coverage through an HMO. Data from a 1989 survey of medium to large size private-sector employers, the *Hay/Huggins Benefits Report*, indicates that of 453 respondents covering retirees over age 65, 33 percent provide a supplement to Medicare (i.e., Medigap coverage), 59 percent provide the same level of coverage (offsetting for Medicare) as for active employees (i.e., a major medical policy or HMO), and 8 percent provide the same level of coverage as for active employees but have separate plan maximums. A 1988 survey of approximately 1,000 employers by the Health Insurance Association of America (HIAA) and the Johns Hopkins University found that 8 percent of retirees with employment-based coverage had Medigap-type coverage.[2]

Health Insurance Association of America 1989 Telephone Survey. HIAA conducted a national telephone survey of 500 elderly Americans (age 65 or more) in April and May of 1989.[3] Of the elderly surveyed, 78 percent (391 individuals) had some type of private insurance to supplement Medicare. Individuals who were jointly eligible for Medicare and Medicaid were excluded from the survey, since they typically do not buy private coverage. If they had been included, the rate of policy ownership would have been lower, about 70 percent.

National Medical Expenditure Survey. The National Medical Expenditure Survey (NMES) is a national health care expenditure survey conducted in 1987 by the National Center for Health Services Research and Health Care Technology Assessment of DHHS. NMES uses a national probability sample of the civilian, noninstitutionalized population in a household survey conducted quarterly in 1987.

Data from the first quarter of 1987 show that approximately 75 percent of the population aged 65 and older with Medicare (approximately 20 million individuals) also had some type of private health insurance coverage.[4]

---

[2] DiCarlo, Steven, John Gabel, Gregory de Lissovoy, and Judith Casper. *Facing Up to Postretirement Health Benefits.* Health Insurance Association of America Research Bulletin, Sept. 1989. p. 10.

[3] Rice, Thomas, Katherine Desmond, and Jon Gabel. *Older Americans and Their Health Coverage.* Health Insurance Association of America Research Bulletin, Oct. 1989. p. 15-20.

[4] Monheit, A., and C. Schur. *Health Insurance Coverage of Retired Persons.* National Medical Expenditure Survey Research Findings 2, National Center for Health Services Research and Health Care Technology Assessment. DHHS Publication No. (PHS) 89-3444, Sept. 1989. p. 8-10.

Approximately 40 percent (11 million individuals) had privately purchased policies and 35 percent (9 million) had employment-related coverage.

Characteristics of Those With Medigap Coverage

The HIAA 1989 telephone survey found that the following groups were most likely to own one or more Medicare supplemental insurance policies: individuals age 80 and under, whites, married, better educated, higher incomes, and those reporting better health status. For most factors, the differences were not great except for race: 82 percent of whites owned policies, while only 33 percent of nonwhites did. Income was not a factor for income levels beyond $10,000.

The 1987 NMES survey found that the likelihood of Medicare beneficiaries aged 65 and older with certain demographic characteristics to have privately purchased policies was as follows:

Race:	44 percent of whites and 16 percent of blacks purchased such policies
Sex:	44 percent of females and 36 percent of males
Age:	33 percent of those age 65-69, 41 percent of those age 70-74, and 46 percent of those 75 or older
Employment status:	40.6 percent of those not employed 40.8 percent of those employed

An earlier (1980) national health expenditure survey conducted by DHHS (the National Medical Care Utilization and Expenditure Survey) provides coverage data by income:[5]

Income	Medigap coverage
Less than $5,000:	41 percent
$5,000-$9,999:	63 percent
$10,000-$19,999:	75 percent
$20,000 or more:	73 percent

Data compiled by the CBO indicates that for those who had private health insurance in 1984, about 44 percent of the elderly with family incomes below $5,000 had supplemental coverage, compared with 87 percent of those with incomes of $25,000 and over.[6]

Numbers of Medigap Policies Purchased by Each Individual

Approximately 85 percent of policy owners responding to the HIAA 1989 telephone survey said they owned one supplemental policy, with the remaining 15 percent claiming to own two or more. Ten sampled individuals (2.6 percent) owned three or more policies, and one individual claimed to own six policies. The HIAA survey found that the following factors were associated with owning multiple policies: higher incomes, and those who had visited the doctor more frequently in the previous year.

An earlier study conducted by Market Facts, Inc., for the HIAA found that in 1987, 75 percent of the 1,730 Medicare beneficiaries surveyed who owned some type of private health insurance policy had one policy; 14 percent had 2 policies; 4 percent had 3 policies; 1 percent had 4 policies.[7]

---

[5] Garfinkel, S., and L. Corder. *Supplemental Health Insurance Coverage Among Aged Medicare Beneficiaries.* National Medical Care Utilization and Expenditure Survey, Series B, Descriptive Rept. No. 5, DHHS Pub. No. 85-20205. Office of Research and Demonstrations. Health Care Financing Administration. Washington, U.S. Govt. Print. Off., Aug. 1985. p. 20.

[6] Prospective Payment Assessment Commission. *Medicare Prospective Payment and the American Health Care System: Report to the Congress.* June 1989. p. 80. From Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey.

[7] Market Facts, Inc. *A Report on Medigap Insurance Policy Ownership and Experience.* Health Insurance Association of America, Mar. 4, 1987.

MEDIGAP REGULATION, INCLUDING THE IMPACT OF P.L. 100-360

Standards in Effect Before 1989

Regulation of private insurance, including health insurance, has been by statute and tradition primarily a State responsibility. To help promote effective and uniform regulation, an organization of State insurance commissioners known as the National Association of Insurance Commissioners (NAIC) develops model standards (both laws and regulations) which can be adopted by individual States. Such standards, both a model law and a model regulation, were adopted by the NAIC for regulation of Medicare supplement (or, Medigap) policies in the mid-1970s, and have been amended numerous times since then.

In general, the NAIC model law and regulations for Medigap policies (a) specified the minimum benefits that such policies must cover (for example, coverage of Medicare coinsurance amounts for days 61 through 90 and for the lifetime reserve days of inpatient hospital care); (b) limited the period for which coverage could be denied for pre-existing conditions; and (c) required cancellation and termination clauses to be prominently displayed.

However, continuing abuses in the sale of Medigap policies led Congress to include in the Social Security Disability Amendments of 1980 (P.L. 96-265, enacted June 9, 1980) a provision for regulation of Medigap policies. Section 507 of P.L. 96-265 added a new Section 1882 to the Social Security Act entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies," also known as the "Baucus Amendment" after the chief sponsor of the amendment, Senator Max Baucus.

Section 1882 establishes Federal minimum standards for Medigap policies based primarily on the June 6, 1979 NAIC model standards. The law does not apply the standards to Medigap plans offered by employers or labor organizations, to policies for specific diseases (e.g., cancer policies), or to hospital indemnity policies (i.e., policies which pay a fixed amount for each day the insured is in the hospital, up to a specified number of days). Section 1882 provides loss ratio requirements for group and individual Medigap policies. ("Loss ratios" are the percentage of insurance premiums returned to policyholders in the form of benefits. They are calculated by dividing the amount of benefits paid by the amount of premiums collected.)

In addition, Section 1882 establishes a Supplemental Health Insurance Panel and a Voluntary Certification Program of Medigap policies by DHHS and provides criminal penalties for certain abusive Medigap sales practices. Actions subject to penalties include making false statements and misrepresentations, falsely claiming certification by the Secretary, selling policies that duplicate Medicare's benefits, and mailing into a State Medigap policies disapproved by that State.

The Federal Medigap standards are implemented in two ways. Individual insurers may voluntarily submit their policies to the Voluntary Certification Program to be certified and authorized to display a Federal emblem if they are found to meet or exceed the minimum standards. Or, recognizing the traditional role of the States in regulating insurance, States may adopt the Federal Medigap standards as part of their regulatory program. The States may then submit their programs for review by the Supplemental Health Insurance Panel. If such State programs meet or exceed the Federal standards, then policies approved in those States are deemed to meet the Federal requirements, and the Voluntary Certification Program does not apply in those States.

In December 1980, the NAIC revised its model standards to incorporate requirements of the new Section 1882 legislation. These standards required such policies to:

- cover all Medicare inpatient hospital coinsurance charges for days 61 through 90 and for the lifetime reserve days;
- cover 90 percent of covered charges after a beneficiary exhausted his or her hospital benefits, subject to a lifetime maximum benefit of an additional 365 days;
- cover the Part B coinsurance, which could be subject to a $200 deductible and a maximum benefit of at least $5,000 per year;
- not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the policy's effective date and not deny a claim, on the basis of preexisting conditions, for services furnished more than 6 months after such effective date;
- return to policyholders in the form of aggregate benefits at least 75 percent of aggregate premiums collected for group policies and at least 60 percent of aggregate premiums collected for individual policies; and
- require that purchasers of a policy have a "free look" period, during which time they could return an unwanted policy for cancellation and receive a full refund of any premium paid.

By 1988, all but four States had adopted the NAIC standards into their regulatory programs. However, the four States that did not receive approval from the Supplemental Health Insurance Panel (Massachusetts, New York, Rhode Island, and Wyoming) had Medigap regulatory programs. Although these States did not include all of the minimum standards, Massachusetts and New York exceeded the minimum standards in certain ways. There have been few submittals under the Voluntary Certification Program, with no policies having been certified to date.

Standards Created by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360)

The enactment of the Medicare Catastrophic Coverage Act of 1988 (or MCCA, P.L. 100-360; July 1, 1988) expanded Medicare's benefits beginning in 1989. Section 221 of MCCA amended Section 1882 to require revision of the Federal minimum Medigap standards (and the NAIC model standards) so that coverage of benefits that duplicated Medicare's new benefits would not be required.

MCCA's Provisions for New and Amended Medigap Standards. MCCA provided that if the NAIC amended its model regulation by October 1, 1988 to reflect changes made by the law, then the amended regulation would apply as a standard for certification. The NAIC met this requirement by adopting an amended model regulation and act on September 20, 1988.

MCCA provided that in order for a State regulatory program to be approved, the new NAIC model standards must apply in a State on the earlier of:

- the date the State adopts standards equal to or more stringent than the amended model regulation, or
- one year after the NAIC first adopts the amended regulation (i.e., September 20, 1989).

After the date the NAIC model standard applies in a State, no new Medigap policy could be certified by the Secretary and no existing secretarial certification could remain in effect unless the policy met the standards of the amended NAIC model regulation. Similarly, State regulatory programs were required to meet or exceed the amended NAIC standards by that date in order to meet approval standards.

MCCA and NAIC Transition Provisions. In September 1987, the NAIC adopted a Model Transition Regulation to implement transitional requirements for the conversion of Medigap policies to conform to what at that time were prospective Medicare program revisions. This Transition Regulation (as subsequently amended September 20, 1988 to reflect MCCA changes) required, for existing policies, that insurers notify beneficiaries of Medicare's benefit changes and changes in their Medigap policy's premiums and benefits (to eliminate duplication), not later than 30 days before the effective date of Medicare benefit changes. In addition, insurers were required to file with the States, within 45 days of Medicare benefit changes, Medigap premium adjustments necessary to produce originally anticipated loss ratios and benefit riders to eliminate duplication. For new policies, the Transition Regulation required that insurers file new policies with the States by December 20, 1988, and that, effective January 1, 1989, no Medigap policy could be issued that duplicated Medicare's benefits.

MCCA permitted the selling of new policies or maintenance of existing certified policies in States that had not adopted either the NAIC Transition Regulation or the NAIC Model Regulation by January 1, 1989, as follows:

- policies issued before January 1, 1989 were deemed to be in compliance if the insurer complied with the amended NAIC Model Transition Regulation by January 1, 1989, and
- new policies issued on or after January 1, 1989 were required to be in compliance with the NAIC Transition Regulation before the date of sale.

MCCA provided that this transition requirement would remain in effect until the earlier of: (1) State adoption of the NAIC Model Transition Regulation or the amended NAIC Model Regulation; (2) 1 year after NAIC adoption of the amended Model Regulation (i.e., September 20, 1989); or (3), in a State requiring State legislation where the legislature is not scheduled to meet in 1989, the first day of the first calendar quarter beginning after the close of the first legislative session beginning on or after January 1, 1989.

In States that had enacted the NAIC Model Regulation but not the NAIC Transition Regulation by January 1, 1989, insurers were required to send a notice to each policyholder by January 31, 1989 explaining the improved Medicare benefits and how these improvements would affect the policy's benefits and premiums.

Other MCCA Medigap Requirements. MCCA contained a number of additional amendments to the Section 1882 requirements, including the following:

- Free-look. A 30-day free-look period is required for all supplemental policies without regard to the manner in which the purchase of the policy was solicited. (Previously, the law required a free-look only to mail order policies.)
- Reporting of information. States with their own Medigap certification programs are required either to use forms developed by the NAIC to collect information on actual loss ratios or provide for monitoring of such ratios in an alternative manner approved by the Secretary.
- Consumer information. The Secretary is required to: (1) inform beneficiaries about marketing and sales abuses subject to sanctions and the manner in which they may report any such action or practice; (2) publish a toll-free telephone number for such individuals to report suspected violations of the laws relating to Medigap standards; and (3) provide beneficiaries with a listing of State and Federal agencies and offices where information and assistance relating to Medigap policies may be obtained.

- **Required submission of advertising.** Entities issuing Medigap policies are required to submit a copy of each advertisement used (or, at State option to be used) to the Commissioner of Insurance (or comparable officer) for review and approval, to the extent required under State law. This provision applies to written, radio, and television ads.

NAIC Model Act and Regulation Revisions. On September 20, 1988, the NAIC adopted modifications to the Medicare Supplement Insurance Minimum Model Standards Act and the Model Regulation to implement that Act. The following highlights the major changes contained in these documents:

- The Model Act and Regulation specifically prohibit duplication of Medicare benefits;
- The Model Act and Regulation require every insurer or other entity providing supplement insurance or benefits in the State to provide a copy of any advertisement intended for use in the State to the Commissioner of Insurance for review or approval (to the extent required under State law);
- The Model Act and Regulation specify that subscriber contracts of hospital and medical service associations and health maintenance organizations (HMOs) that are designed primarily to supplement Medicare's benefits are included within the definition of Medicare supplement policies;
- The Model Regulation requires insurers to notify policyholders, at least 60 days in advance of the effective date of the new benefit changes, of the appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the policies. Premium adjustments are to be in the form of refunds or premium credits. No other premium adjustment can be made at any time other than the anniversary or renewal date.
- The Model Regulation specifies that the following minimum benefit standards apply:
    - Coverage of either all or none of the Medicare inpatient hospital deductible;
    - Coverage of the daily copayment charge (i.e., for the first 8 days) for skilled nursing facility (SNF) services;
    - Under Medicare Part A, coverage of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations or already paid for under Part B. (This is known as the Part A blood deductible.)

- Effective January 1, 1990, coverage of Part B coinsurance for Medicare eligible expenses (excluding outpatient prescription drugs) up to the Medicare maximum out-of-pocket amount, after the Medicare deductible amount;

- Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare Part B deductible amount. (This is known as the Part B blood deductible.)

- Effective January 1, 1990, coverage for the coinsurance for home intravenous (IV) therapy drugs, subject to the drug deductible; and

- Effective January 1, 1990, coverage for the coinsurance for covered outpatient immunosuppressive drugs, subject to the drug deductible, if applicable.

The NAIC minimum benefits do not require the coverage of prescription drug expenses incurred by the beneficiary before satisfying the deductible. Further, with the exception of the coverage of coinsurance for home IV drugs and immunosuppressive drugs as noted above, no coverage is required for drug coinsurance charges imposed once the beneficiary has met the drug deductible. Coverage for coinsurance for home IV drugs is limited to drugs subject to the deductible; the deductible does not apply in cases where the drug is furnished in connection with home IV therapy services initiated in the hospital.

States That Took Action.. By September 1989, all States except Massachusetts had adopted, at least in proposed form, the amended NAIC standards.[8] As of September 13, 1989 (the most recent meeting of the Supplemental Health Insurance Panel), the Panel had fully approved the Medigap regulatory programs of 21 States and had conditionally approved 28 States, the District of Columbia, Puerto Rico, and the Virgin Islands. By December 1989, 10 of the conditionally approved States had finalized their programs.

---

[8] Massachusetts has a program to regulate Medigap policies which exceeds the standards in some ways, but does not include several of the NAIC minimum standards. For example, Massachusetts requirements do not apply to Medigap policies sold on a group basis.

Standards Created by the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234)

Legislation repealing most of the MCCA Medicare benefit expansions was signed into law on December 13, 1989 (the Medicare Catastrophic Coverage Repeal Act of 1989, P.L. 101-234). This law also required revision of the NAIC Medigap standards, this time to expand the minimum benefit requirements to compliment the reduction in Medicare's benefits. In order for a policy to be certified, it has to meet the revised standards by the earlier of the date the State adopts the revised standards, or one year after the NAIC adopts the revised standards (i.e., December 13, 1990).

P.L. 101-234 included a transition provision as follows:

- policies issued before December 13, 1990 are deemed to be in compliance if the insurer complies with the amended NAIC Model Transition Regulation, and
- policies issued on or after December 13, 1990 are required to be in compliance with the revised NAIC Model Regulation before the date of sale.

P.L. 101-234 provides that this transition requirement would remain in effect until the earlier of: (1) State adoption of the revised NAIC Model Regulation, or (2) in a State requiring State legislation where the legislature is not scheduled to meet in 1990, the first day of the first calendar quarter beginning after the close of the first legislative session beginning on or after January 1, 1990.

In order to meet the standards, for policies in effect on January 1, 1990, insurers are required to send notices to policyholders by January 31, 1990 explaining the changes in Medicare's benefits and how these changes may affect the benefits and premiums of the Medigap policy.

P.L. 101-234 also includes a provision requiring reinstitution of coverage to individuals who had a Medigap policy in effect on December 31, 1988 and who terminated coverage before December 13, 1989. Insurers must provide such individuals written notice between December 15, 1989 and January 30, 1990 and must offer to such individuals during a 60-day period beginning not later than February 1, 1990, reinstitution of their Medigap coverage (beginning January 1, 1990). Such coverage may not require a waiting period for treatment of pre-existing conditions, must include coverage that is substantially the same as coverage in effect before the termination, and must provide for classification of premiums with terms at least as favorable to the policyholder as the premium classification terms that would have applied if the policy had never been terminated. Insurers do not have to offer reinstitution of coverage to individuals who have another Medigap policy on December 13, 1989, if (as of January 1, 1990) that individual is not subject to a waiting period for treatment of a pre-existing condition under the other policy.

The NAIC approved revised standards on December 7, 1989, which became effective when P.L. 101-234 was signed into law on December 13, 1989. These standards include new minimum benefit standards and prohibitions against certain abusive marketing practices, as follows:

- Coverage of the following minimum benefits:
    - Part A Medicare eligible expenses for hospitalization not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period (Medicare's daily coinsurance is $148 in 1990);
    - either all or none of the Medicare Part A inpatient hospital deductible ($592 in 1990);
    - Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days (Medicare's daily 1990 coinsurance for lifetime reserve days is $296);
    - after exhausting all Medicare hospital inpatient benefits including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days;
    - the Part A blood deductible;
    - the coinsurance amount of Medicare eligible expenses under Part B (currently 20 percent) regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (currently $75). (Effective January 1, 1990, coverage for the 20 percent coinsurance amount for Medicare eligible expenses for covered outpatient drugs used in immunosuppressive therapy, subject to the Medicare Part B deductible amount, is included in this provision.);
    - effective January 1, 1990, the Part B blood deductible.
- Requirements regarding policy cancellations, including the offering of conversion to individual policies for group policy cancellations;
- Requirements regarding permitted agent compensation arrangements;
- Certain marketing standards, including prohibitions against high pressure tactics, twisting, and cold lead advertising;

- A requirement that, on or before March 1 each year, Medigap insurers must report information on individuals who are covered by more than one Medigap policy;
- A prohibition against new pre-existing condition clauses, waiting periods, elimination periods, and probationary periods in replacement policies;
- Application forms for Medigap policies must include questions designed to find out if the applicant has another Medigap policy or is eligible for Medicaid. Also, agents must list all health policies sold to the Medigap applicant in the past 5 years.

The reapproval process of State regulatory programs necessitated by the repeal of MCCA has not yet begun.

MEDIGAP PREMIUMS

Medigap premiums vary depending on the extent of benefits covered (and the allowable charges made by health care providers to provide those benefits), and other factors such as the extent of utilization of health care services by the covered population, administrative costs, insurance company profit, and reserve requirements. In addition, the cost of a plan can vary depending on the age and geographic location of the enrollee.

The 1989 HIAA Telephone Survey mentioned above found that the mean 1989 annual Medigap premium was $718 and the median was $640.[9] (Note that 1989 Medigap policies generally included fewer benefits than policies of prior or later years because of the more extensive Medicare coverage resulting from the Medicare Catastrophic Coverage Act of 1988, or MCCA.)

Medigap Premium Increases

In 1989, the staff of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, conducted a telephone survey of officials in the State Departments of Insurance regarding recent Medigap premium increases. They found that the 1989 premium increases in the 44 States responding to the survey ranged from 10 percent to 133 percent. In addition, the staff asked questions to ascertain the degree to which Medigap rates and rate changes are scrutinized by the States. They found that 73 percent of the 44 States required that Medigap premium increases for individual policies be formally approved by the State before going into effect; the proportion requiring formal approval for group Medigap policies was 36 percent.[10]

---

[9] Rice et al., *Older Americans and Their Health Coverage,* p. 16.

In preparation for hearing testimony before the Senate Special Committee on Aging on January 8, 1990, the General Accounting Office (GAO) contacted 29 commercial Medigap insurers to obtain their current estimate of their 1990 premiums and their reasons for premium changes. As stated in the GAO testimony, 20 companies, selling policies covering about 2.6 million policyholders, responded.[11] The average increase in the 1990 premiums over 1989 is estimated to be 19.5 percent, or $11.44 per month. The increases ranged from 5.0 percent to 51.6 percent. Only one company reported that its expected 1990 premium would be the same as in 1989. The average monthly 1989 premium was $58.52 (or, $702.24 per year); the average monthly premium for 1990 was $69.96 (or, $839.52 per year).

GAO found that there were four reasons why Medigap insurers expected to increase their premiums in 1990. One-half of the 19.5 percent increase was expected to result from general inflation in the cost of medical care, increased utilization of medical services by senior citizens, and higher than expected claims experience in prior years. The other half of the increase was attributed to the repeal of MCCA, including the addition of benefits and the administrative costs associated with repeal, such as modifications to policies and notices to policyholders.

The Blue Cross and Blue Shield Association estimated the 1990 premium increases for Medigap policies offered by Blue Cross/Blue Shield plans as follows. The median 1989 nongroup annual premium was $576. The median 1990 rate increase prior to repeal of MCCA was projected to be 9 percent, or $52. The median 1990 rate increase after MCCA repeal was projected to be an additional 29 percent, or $167. Together, the median increase for 1990 would total $219, or 38 percent, resulting in a 1990 median annual premium of $795. Blue Cross/Blue Shield indicated that the increases could range from $96 to $288 if MCCA were repealed, or from 17 percent to 50 percent of the amounts projected prior to Medicare Catastrophic repeal. These amounts do not reflect additional increases plans might apply to adjust for prior rate inadequacies.

---

[10] U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care. *Changes in the Costs of Medigap Insurance: a Fifty State Survey*. Committee Print, 101st Congress, 1st Sess. Washington, Nov. 2, 1989. p. 1-5.

[11] U.S. General Accounting Office. *MEDIGAP INSURANCE: Expected 1990 Premiums after Repeal of the Medicare Catastrophic Coverage Act*. Testimony of Janet Shikles before the Senate Special Committee on Aging. Harrisburg, Pennsylvania, Jan. 8, 1990. p. 5-6.

Loss Ratio Standards

One of the ways in which Medigap premiums are regulated is through loss ratio standards. A loss ratio is the ratio of the claims paid under a policy to the premiums earned (i.e., collected). Section 1882 of the Social Security Act as added by P.L. 96-265 included requirements for Medigap policies to meet certain loss ratio standards. Section 1882 required that the expected loss ratio for Medigap policies be at least 60 percent for individual policies and 75 percent for group policies. This requirement was incorporated into the December 1980 NAIC model standards.

In December 1987, the NAIC revised its Medigap standards to require insurers to file loss ratio information and to comply with actual loss ratios. MCCA (P.L. 100-360) included a provision requiring approved State Medigap regulatory programs either to require information from insurers on actual loss ratios, reported on forms conforming to those developed by the NAIC, or to monitor such ratios in an alternative manner approved by the Secretary of DHHS. Additional requirements regarding loss ratio information were included the NAIC standards approved September 20, 1988, which were subsequently adopted by almost all States.

A 1986 study by the GAO of the loss ratios of individually purchased Medigap policies found that the loss ratios of most of the policies surveyed were below the Section 1882 targets. However, the loss ratios of the most commonly purchased policies, those of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Company, were generally above the targets. The 92 commercial insurance companies for which 1984 loss ratio data was obtained had an aggregate loss ratio of 60.2 percent. This loss ratio was substantially influenced by the 77.9 percent loss ratio of the Prudential Life Insurance Company, which had nearly one-fourth of the total earned premiums. The 13 Blue Cross/Blue Shield plans had an aggregate loss ratios of 81.1 percent during 1984.[12]

In early 1989, GAO obtained 1987 loss ratio information on Medigap plans that had a total of about $4.9 billion in premiums in 1987. The 1987 loss ratios for the 92 individually-purchased commercial policies averaged 74 percent; their total premiums were over $1.7 billion. The relatively high loss ratio of Prudential (83 percent) again helped raise the overall average, which without Prudential would have averaged 59 percent. The 75 individual Blue Cross/Blue Shield plans had total 1987 earned premiums of $2.6 billion and an average loss ratio of 93 percent. For group plans, the Blue Cross/Blue

---

[12] U.S. General Accounting Office. *Medigap Insurance; Law has Increased Protection Against Substandard and Overpriced Policies.* GAO/HRD-87-8, Washington, Oct. 1986. p. 4.

Shield plans earned premiums totalling $600 million, with loss ratios averaging 96 percent.[13]

MEDIGAP BENEFITS

As described earlier in this paper, the minimum standards for Medigap policies have been determined through Section 1882 of the Social Security Act and through model laws and regulations developed by the National Association of Insurance Commissioners (NAIC) and adopted by the States. A primary prohibition is that Medigap policy benefits may not duplicate Medicare's benefits. The NAIC benefit standards, and their changes in recent years, can be found in an earlier section of this paper under "Medigap Regulations, Including Impact of P.L. 100-360."

The NAIC model regulations also provide for a definition of Medicare eligible expenses. They are "health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims." Thus, the NAIC standards do not require Medigap policies to cover expenses that Medicare does not consider eligible, i.e., expenses that exceed Medicare's payment rules or that are not considered medically necessary by Medicare.

Few studies have surveyed Medigap policy benefits. In its June 1989 issue, *Consumer Reports* rated 28 Medigap policies ranging in price from about $500 to about $1,300 per year.[14] All of the policies reviewed by *Consumer Reports* covered the inpatient hospital deductible ($560 in 1989). All covered Medicare's skilled nursing facility coinsurance, which is required by the NAIC standards. About 60 percent of the policies reviewed (17 policies) covered skilled nursing care after Medicare's 150 days of coverage. For Part B services, many policies paid only the 20 percent coinsurance for Medicare's allowable charges. Less than half of the policies (13 policies) covered the $75 Medicare Part B deductible. Less than half (13 policies) paid no physician charges above Medicare's allowable amounts, and only one of the policies reviewed paid all excess physicians' charges. Half of the plans included what *Consumer Reports* indicated was a substantial out-of-hospital prescription drug benefit.

---

[13] U.S. General Accounting Office. *MEDIGAP: INSURANCE, Effects of the Catastrophic Coverage Act of 1988 on Future Benefits*. Testimony of Michael Zimmerman before the Senate Committee on Finance, June 1, 1989. p. 9-11.

[14] Beyond Medicare. *Consumer Reports*, June 1989. p. 375-391.

In an April 1987 Fact Sheet, the Blue Cross and Blue Shield Association indicated that the Blue Plans' nongroup Medigap policies met or exceeded State and Federal benefits standards and, in addition, included the following benefits:

- 88 percent covered Part B expenses beyond the $5,000 minimum required by the State-adopted NAIC standards;
- 84 percent covered the deductible for each hospital admission ($520 in 1987);
- 86 percent covered skilled nursing facility coinsurance (80 days at $65 per day);
- 63 percent covered the Part B deductible ($75);
- 43 percent covered outpatient prescription drugs;
- 36 percent covered skilled nursing facility days after expiration of Medicare's 100-day benefit;
- 29 percent covered vision care.

SALES PRACTICES BY THE MEDIGAP INDUSTRY

Section 1882 of the Social Security Act (the Baucus Amendment) was enacted in response to widespread reports of abusive sales practices in Medigap policies sold to the elderly. It is generally believed that these practices have diminished since enactment of that law. However, violations still occur. Testimony by consumer groups and attorneys before the House Energy and Commerce Committee in April 1989 and similar testimony by the Southwest Regional Office of Consumers Union before the Senate Finance Committee in June 1989 cited a number of violations. The types of abusive sales practices cited by these witnesses include the following:

- misrepresentation;
- selling policies which duplicate coverage the senior already has;
- twisting (where agents encourage the elderly to switch, or "twist," old policies for new ones because of the substantially higher commissions on new policies);
- generating lists of names to sell to insurance agents ("lead developing") through ads offering information about Medicare; and
- selling low value hospital indemnity policies or dread disease policies to persons who already have Medicare and Medigap.

The NAIC, in its testimony before the Energy and Commerce Committee, agreed that some abuses still occur. However, it stated that the incidence was considerably less than it was 8 years ago when Section 1882 was enacted or even 3 years ago because of the efforts of State insurance commissioners and the NAIC. It noted that in the 11 States that specifically track Medicare supplement complaints, 8 reported less than 10 percent of insurance complaints relating to Medicare supplement policies while 3 States reported a figure slightly over 10 percent.

The NAIC cited a number of recent actions designed to curtail abusive activities including:

- extensive consumer education activities on the part of the States;
- State action barring and penalizing agents for selling duplicative coverage;
- NAIC restrictions on payment of first year commissions for replacement business; and
- adoption of *NAIC Rules Governing Advertisements of Medicare Supplement Policies* that include restrictions on celebrity advertising.

PREPARED STATEMENT OF GAIL SHEARER

Mr. Chairman and members of the Subcommittee, Consumers Union[1] appreciates the opportunity to present our views on the issue of private health insurance to supplement Medicare ("Medigap" insurance) The Federal Government has a special obligation to monitor the performance of this market, since the design of its own Medicare program has in effect created the supplemental market, and because there is a great deal of confusion about where Medicare ends and private responsibility for health care costs begin. Medigap premiums seem to increase regardless of whether Medicare benefits grow or shrink, and this troubles consumers. We urge the congress to use the window of opportunity it now has—with the growth of the medigap market after the repeal of the catastrophic bill—to both critically review and improve the performance of the medigap market. True reform of this market would be an appropriate way to celebrate the 25th anniversary of the enactment of the Medicare program.

In my testimony, I plan to describe the key abuses in the medigap market and propose five recommendations for legislation to eliminate these abuses.

MARKETING ABUSES AND MARKET FAILURE

Following the enactment of the Baucus amendment in 1980, there was relatively little publicity about abuses in the medigap market. But, unfortunately, this was not because the Baucus amendment had dramatically improved the performance of the market. The June 1989 issue of Consumer Reports provides some disturbing information about marketing abuses. The article uncovered examples of agent ignorance, high-pressure marketing techniques, agent efforts to sell unnecessary policies, frivolous variation between policies, and a marketplace characterized by confusion rather than clarity. The article concludes that the Baucus amendment has not cleaned up the Medicare supplement industry. "Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the [amendment] requires." A copy of the article is attached to my testimony. Some of the key areas of market failure are described below:

---

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of **Consumer Reports**, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, **Consumer Reports**, with approximately 4 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

1. *Consumer Confusion and Lack of Knowledge:* The proliferation of policies makes it virtually impossible for consumers to make an informed purchase decision. Research conducted after the enactment of the Baucus amendment shows that beneficiary knowledge of Medicare and medigap coverage is low. If consumers are misinformed about Medicare coverage, they are likely to be susceptible to sales pitches leading to more supplemental coverage than they need.[2]
2. *Dunlicate Coverage/Overselling.* Some people buy more than one medigap policy, paying thousands of dollars in premiums to buy overlapping, duplicative coverage. Since companies do not tend to coordinate benefits, these consumers are able to collect benefits from all of the policies they own. The point here is that uninformed consumers, who are fearful of health care costs, waste their limited dollars by over-insuring. Attached to my testimony are some troubling examples of consumers who were persuaded to buy multiple policies. Equally troubling, though, is the large percent (15 percent by the industry's latest survey) of senior citizens who own two or more policies. The regulatory system should provide a market structure that allows consumers to spend their limited dollars on just one policy to meet their needs.
3. *Low-Value.* The General Accounting Office's 1986 results about loss ratios were disturbing. While the Baucus amendment established a target loss ratio of 60 percent for individual policies, the GAO found that 254 of the 398 policies (64 percent) it reviewed had loss ratios below the target. The average loss ratio for commercial medigap policies was only 60 percent.[3] The General Accounting Office's recent report on 1987 loss ratios showed little improvement; 50 of the 91 policies (55 percent) reviewed had loss ratios under 60 percent.[4]
4. *Twisting.* Twisting is the term used to describe a common agent practice of convincing a client to switch policies. Agents have an incentive to do this since many policies have front-loaded commissions. In other words, the agent earns a hefty commission for first-year premiums, and much less for policy renewals. Consumers often do not benefit from being "twisted" to a different comparable policy, and face increased costs of uncovered charges, since they face new exclusions for pre-existing conditions.
5. *Deceptive Lead Card Company Practices.* As described in Consumer Reports, lead card companies send out mailings to senior citizens, requesting that the recipient fill in and return the card enclosed in the mailing. In many cases, the mailings use names to make recipients think that the sender is a government official. Some of the names include: National Health Information Center; Consumer Referral Service Center, Medicare Division; and Senior Citizens Health Services. Some companies use mailing addresses that are post office boxes in Washington, D.C., to give the impression of a government connection.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER'S REVISED MODEL REGULATION

In December, 1989, the National Association of Insurance Commissioners (NAIC) revised its model regulation of medigap. The NAIC should be commended for taking several positive steps, including:

—prohibiting pre-existing conditions on replacement business;
—prohibiting the sale of a policy if the purchasers's total coverage would exceed 100 percent of actual medical expenses;
—encouraging state counseling efforts.

The NAIC actions, however, will not solve all medigap problems. There are uncertainties about whether states will enact the changes, and there are substantial uncertainties about whether the regulation as written is enforceable and whether states will devote sufficient resources to enforce them. In addition, we regret that the NAIC chose not to take steps to standardize the medigap market. We continue to believe that consumers desire a meaningful range of choice in this market.

---

[2] Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits"' Health Services Research 20:6 (February 1986, Part I), pp. 642, 649.

[3] *Medigap Insurance,* Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, October 1986.

[4] *1987 Loss Ratios of Selected Medigap Insurance Policies,* General Accounting Office, April 1989.

RECOMMENDATIONS FOR CONGRESSIONAL ACTION

1. *Congress should establish a grant program to encourage states to establish comprehensive counseling programs for health insurance for the elderly.* Twelve states have counseling programs that train volunteers to sit down with the elderly on a one-on-one basis to counsel them about Medicare, private Medicare supplement insurance and long-term care insurance. The Health Insurance Counseling and Advocacy Program (HICAP) in California and Senior Health Insurance Benefits Advisers (SHIBA) in some other states have been extremely effective in eliminating duplicative coverage and advising senior citizens of their coverage and their choices. The HICAP program, for example, estimates that by eliminating inappropriate coverage, senior citizens have saved twice as much money as the program costs. Congress should encourage all the states to establish their own counseling programs, by establishing a grant program and an information clearinghouse.

2. *Congress should STANDARDIZE the Medicare supplement insurance market.* Standardization of the market should be the centerpiece of regulatory reform. Under standardization, the government would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions (such as length of pre-existing condition period). In a standardized market, policy benefits could not vary from standard levels set forth in "low," "medium," and "high" policies, which would range from less comprehensive to more comprehensive. Policy standardization should be distinguished from "minimum standard" types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. Under standardization, no such variation is allowed.

As part of the standardization package, there should be a prohibition of the sale of duplicative coverage. No person should own more than one Medicare supplement insurance policy. The National Association of Insurance Commissioners (NAIC) rejected standardization and adopted a minimum standard regulatory approach to medigap in 1979 (and once again in December, 1989, when it revised the model). The Congress endorsed the original NAIC approach in 1980 in the Baucus amendment. After ten years, we know that this approach is inadequate. It is important for Congress to look beyond the original NAIC (and Congressional) regulatory approach to the innovative work of a handful of states that have embraced the concept of standardization to the benefit of their consumers.

Wisconsin led the states into standardization in 1978 when it adopted a rule establishing four distinct categories of Medicare supplement insurance coverage. While the goal of the regulation was to limit variation between policies and to promote consumer understanding, companies gradually undercut this goal by offering optional riders that made it impossible for consumers to rationally compare policies. As a result, Wisconsin recently revised its regulation to end the variation. Policies offered for sale as of January 1, 1989 are required to offer one standard minimum benefits package, with any of six standard riders (including coverage of the Part A deductible, excess charges, and foreign travel). No other benefits can be offered.

In 1980, Massachusetts adopted a "mandatory standardization benefit" approach for regulating the medigap market. The regulation established three levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the three benefit options and cannot be modified. Not only did this lead to a dramatic decrease in consumer complaints, but it also resulted in very favorable loss ratios—which measure the percent of premiums that are paid to policyholders as benefits.

Minnesota recently passed legislation changing its quasi-standardization approach (four minimum levels of coverage, which could be exceeded) to true standardization (two levels, with two optional riders, but no other benefits allowed). The state insurance department had found that the minimum benefit approach led to a proliferation of benefit choices and an inordinate amount of consumer confusion. The law also changes the commission structure to a level commission for the first four years of the policy.

Support for standardization comes from people who are deeply involved in coming to the rescue of elderly people who have been victims of medigap abuses. At recent hearings of the Oversight Subcommittee of the House Energy and Commerce Committee, several witnesses called for standardization of the market. Don Gartner, an Assistant District Attorney for Santa Cruz County, California, whose office is litigating two civil lawsuits involving insurance and the elderly, said:

> Standardization of policies is important. California has about 200 Medicare Supplements approved for sale, with myriad ways of covering in dense language the same item. With such variation, there is little competition on price or quality of product. A consumer, old or young, cannot set two Medicare Supplement policies side-by-side and make an informed choice as to which is better or chapter. Neither, for that matter, can a District Attorney or Department of Insurance regulator readily determine that a policy duplicates an earlier one in order to decide whether to prosecute for twisting.

Emory Walton, the Criminal District Attorney for Eastland County, Texas, with twenty years experience prosecuting fraud cases, also supported standardization:

> Uniformity of Health Care Policies: Today, there are almost as many types of health care insurance policies as Carter has liver pills . . . consequently the elderly are often misled or confused, and the easy victims of abuse in health insurance sales. In the casualty insurance field, there are generally accepted automobile and homeowners' policies which provide all of the coverages normally needed and allow the insured to choose the coverages and amounts deemed appropriate. A similar type of generally accepted health insurance policy could be developed for all types of health care insurance.

3. *The sale of duplicative policies should be banned.* Many consumers buy more than one medigap policy or a combination of a medigap policy, hospital indemnity policy, and dread disease policy, with hopes of being assured of protection against uncovered health care costs. Standardization, banning hospital indemnity and dread disease policies, and counseling would go a long way toward ending the purchase of wasteful coverage. Both the Federal Trade Commission (FTC) staff and the General Accounting Office (GAO) have recently investigated hospital indemnity and specified disease policies and concluded that they do not meet the health insurance needs of the elderly. The FTC staff found that "neither of these policies should be considered to be a good alternative for persons seeking broad coverage of costs for health care that Medicare does not pay." The GAO reported that these policies are of limited value.[5] In addition, agents. should be required to ask (and get responses in writing) about Medicaid eligibility and ownership of other health insurance policies. Agents should be subject to high monetary penalties for selling duplicative policies. The NAIC recently changed its model regulation, prohibiting the sale of a policy if it leads to coverage of more than 100 percent of actual medical expenses (from combined policies). While this is a step in the right direction, we believe it will be very difficult to enforce.

4. *Conaress should reform the commission structure for the sale of Medicare supplement insurance policies.* In order to eliminate high first year commissions, which are the driving force that leads many agents to "churn" their policyholders from one policy to another, high first year commissions (*e.g.*, 70 percent of premiums) should be banned. A level commission structure (*e.g.*, level for the first four years, decreasing in later years) should be adopted. Some states (*e.g.*, Minnesota) have already taken this desirable step, but a national approach is desirable in order to make this policy uniform and to avoid an incentive for unscrupulous agents to move to more lucrative states.

The NAIC recently changed its model regulation by limiting first year commissions to no more than 200 percent of second year commissions. If a policy is replaced, the new policy must be better than the old policy in order for the agent to earn the higher first year commission level. While this approach will probably help somewhat, we are concerned about the enforcement burden of this type of regulation and believe that level commissions may be more effective.

5. *The states should be required to effectively enforce actual (not target) loss ratios.* The Baucus amendment set a 60 percent loss ratio for individual Medicare supplement insurance policies. The NAIC has modified its model regulation to require actual loss ratios of 60 or 65 percent for individual policies. The Congress should make it clear that it believes that loss ratios should be effectively enforced, and should consider increasing the level to 70 percent for individual policies and 80 percent for group policies.

---

[5] *Marketing of Medigap. Specified Disease and Hospital Indemnity Insurance to the Elderly: Report to the Committee on Energy and Commerce, U.S. House of Representatives* by the Federal Trade Commission, Bureau of Consumer Protection, September 1988, p. 128; *Health Insurance: Hospital and Specified Disease Policies are of Limited Value,* General Accounting Office, July 1988.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively. Consumers Union appreciates the opportunity to present our views.

EXAMPLES OF VICTIMS OF OVERSELLING

Senior citizens all over the country are victimized by agents and companies who sell them multiple health insurance policies. From Bonnie Burns, Medicare Specialist, California:

—An 84-year-old woman (with no children) was sold 18 health insurance and life insurance policies by one agent, 2 policies by a second agent, though she already owned 2 group policies as a retired teacher. During an 18 month period, she paid just under $50,000 for 15 of these policies. (Ms. Burns filed a case on her behalf in August 1989.)

From Gerhardt Lehmkuhl, Attorney, Missouri:

—A 70-year-old client was sold at least 27 health insurance policies.
—Widow in her 90's was sold 12 Medicare supplement policies by 5 different agents from different agencies. (He recovered $5800 in premium for her).

From Don Gartner, Assistant District Attorney, Santa Cruz, California:

—Widow, now 83, was sold 12 insurance policies in 1 year by an agent, and paid $6,000 in premiums in 1985 alone. 5 of these policies were either Medicare supplement insurance or related to Medicare supplement insurance policies.
—79 year old woman was sold 24 policies, including 7 Medicare supplement policies, in less than 6 years.
—87-year-old woman was sold 19 policies in three and one half years, including 6 Medicare supplements.
—An elderly couple (whose only income was $838 a month from Social Security) was sold 9 policies by one agent in 1985 alone.

From Emory Walton, Criminal District Attorney for Eastland county, Texas:

—An elderly couple (in their 80's) was sold 13 health insurance policies (and 12 life insurance policies).

From George Davis, retired "Gapline" volunteer in Fort Worth, Texas:

—An elderly couple living on social security income only was sold 6 supplemental policies, including 1 cancer policy and 1 hospital indemnity policy. One of the Medicare supplement policies was from the 1950's and paid only $10 a day for hospitalization. The couple was so broke from paying for their policies that they had to get assistance from the city to pay for their house.

Quoting from Senior Consumer Alert: A Special Bulletin for complaint Handlers, Prepared by the National Consumer Law Center, Produced by the American Association of Retired Persons in cooperation with the National Association of Attorneys General:

—In one seven-month period, Mrs. P., an 85-year-old widow, was sold eight health insurance policies by the same insurance agent. Some of these policies, with yearly premiums totaling $7529, contained overlapping coverage. Others were of little or nor real benefit. Mrs. P. was unwilling to file a complaint against the agent because he know her address and she feared that he would return to confront her.
—Mrs. R., an 89-year-old widow, was persuaded by her agent to spend much of her $12,000 savings account on 11 similar policies. He would visit her about three times a year to change or add to her coverage. When she complained that she could not afford the costly premiums, he told her shoe would be facing certain financial ruin unless she borrowed the money from friends or family. Mrs. R. never reported the agent because she was not award of any wrongdoing on his part.
—Mr. H. wrote a check for $344 and gave it to his insurance agent a young man with a "very, very nice personality." He thought he was paying premiums on his medigap policy, but later discovered he had bought a new policy, which he did not want. He sent the policy back but could not get a refund or any response. He finally wrote the Florida Insurance Commissioner. "I am 90 years

old and [it] seems as thought everyone wants to take advantage of me. Please help me if your can."

Quoting from Harold Halfin, volunteer, Dunn County Office of Aging, Wisconsin, testimony before Senator Herbert Kohl, December 7, 1989:

—92-year-old widow, whose income is just above the medical assistance level, thought she was buying insurance coverage for a nursing home. She currently has a comprehensive Medigap policy with an HMO. An insurance agent called on her and found she was concerned about nursing home coverage and proceeded to tell her he had the policy she needed. She paid him $861 for another policy that was nothing more than a Medigap policy with coverage considerably less than her HMO. The agent would have collected 60 percent or $516.60 for his day's work.

—A 76 year old widow who shows serious signs of dementia has no family support and loves to have visitors. She also is unable to say no to insurance agents. Her banker asked the county benefit specialist to investigate when this woman was over drawing her accounts due to a number of large checks written to insurance companies. During a two year period, this woman had bought 15 different insurance policies. Two other additional Medicare supplements had recently lapsed. The policies included seven Medicare Supplements, one daily indemnity, five life insurance and two cancer policies. Several agents switched her regularly every year to either a new company or a new policy for her Medicare supplement. Other agents sold her one of each kind of policy. With the assistance of the benefit specialist and the Office of the Insurance Commissioner some money was recovered however most of the policies lapsed or were canceled.

Attachment.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively. Consumers Union appreciates the opportunity to present our views.

EXAMPLES OF VICTIMS OF OVERSELLING

Senior citizens all over the country are victimized by agents and companies who sell them multiple health insurance policies. From Bonnie Burns, Medicare Specialist, California:

—An 84-year-old woman (with no children) was sold 18 health insurance and life insurance policies by one agent, 2 policies by a second agent, though she already owned 2 group policies as a retired teacher. During an 18 month period, she paid just under $50,000 for 15 of these policies. (Ms. Burns filed a case on her behalf in August 1989.)

From Gerhardt Lehmkuhl, Attorney, Missouri:

—A 70-year-old client was sold at least 27 health insurance policies.

—Widow in her 90's was sold 12 Medicare supplement policies by 5 different agents from different agencies. (He recovered $5800 in premium for her).

From Don Gartner, Assistant District Attorney, Santa Cruz, California:

—Widow, now 83, was sold 12 insurance policies in 1 year by an agent, and paid $6,000 in premiums in 1985 alone. 5 of these policies were either Medicare supplement insurance or related to Medicare supplement insurance policies.

—79 year old woman was sold 24 policies, including 7 Medicare supplement policies, in less than 6 years.

—87-year-old woman was sold 19 policies in three and one half years, including 6 Medicare supplements.

—An elderly couple (whose only income was $838 a month from Social Security) was sold 9 policies by one agent in 1985 alone.

From Emory Walton, Criminal District Attorney for Eastland county, Texas:

—An elderly couple (in their 80's) was sold 13 health insurance policies (and 12 life insurance policies).

From George Davis, retired "Gapline" volunteer in Fort Worth, Texas:

—An elderly couple living on social security income only was sold 6 supplemental policies, including 1 cancer policy and 1 hospital indemnity policy. One of the Medicare supplement policies was from the 1950's and paid only $10 a day for hospitalization. The couple was so broke from paying for their policies that they had to get assistance from the city to pay for their house.

Quoting from Senior Consumer Alert: A Special Bulletin for complaint Handlers, Prepared by the National Consumer Law Center, Produced by the American Association of Retired Persons in cooperation with the National Association of Attorneys General:

—In one seven-month period, Mrs. P., an 85-year-old widow, was sold eight health insurance policies by the same insurance agent. Some of these policies, with yearly premiums totaling $7529, contained overlapping coverage. Others were of little or nor real benefit. Mrs. P. was unwilling to file a complaint against the agent because he know her address and she feared that he would return to confront her.

—Mrs. R., an 89-year-old widow, was persuaded by her agent to spend much of her $12,000 savings account on 11 similar policies. He would visit her about three times a year to change or add to her coverage. When she complained that she could not afford the costly premiums, he told her shoe would be facing certain financial ruin unless she borrowed the money from friends or family. Mrs. R. never reported the agent because she was not award of any wrongdoing on his part.

—Mr. H. wrote a check for $344 and gave it to his insurance agent a young man with a "very, very nice personality." He thought he was paying premiums on his medigap policy, but later discovered he had bought a new policy, which he did not want. He sent the policy back but could not get a refund or any response. He finally wrote the Florida Insurance Commissioner. "I am 90 years

A REPRINT FROM CONSUMER REPORTS MAGAZINE

Consumer Reports

BEYOND MEDICARE

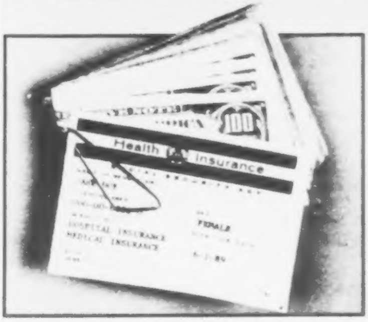
- WHAT INSURANCE DO YOU NEED?
- WHICH POLICIES ARE BEST?
- THE INSURANCE HARD SELL

A reprint from the June 1989 issue of Consumer Reports magazine.

This report was reprinted, for educational purposes only, from the June 1989 issue of Consumer Reports, the monthly magazine published by Consumers Union, a nonprofit organization. Copyright © 1989 by Consumers Union of United States, Inc., Mount Vernon, N.Y. 10553.

RO88

BEYOND MEDICARE



When President Lyndon B. Johnson signed the Medicare Act in the summer of 1965, he promised that older Americans would never be denied "the healing miracle of modern medicine," nor would "illness crush and destroy the savings they had so carefully put away." For the last quarter century the Federal government has struggled to keep that promise, spending ever-increasing sums on health care for the elderly. The Government spent only $3.2-billion on Medicare in 1967, the first year benefits were paid; by 1988 the bill came to nearly $88-billion.

For elderly patients, the cost of medical services not fully covered by Medicare has risen apace, indeed threatening to "destroy the savings they had so carefully put away."

It took 20 years from the time President Harry S. Truman proposed a Government-funded medical insurance plan to the time Congress finally passed one. During all those years, Medicare was held hostage to the charge of "socialized medicine"—the rallying cry of its political opponents, led by the American Medical Association, the American Hospital Association, and other arms of organized medicine.

To overcome that charge, Medicare's proponents finally chose as their model for paying hospitals and doctors the system long used by Blue Cross and Blue Shield plans, insurance reimbursement systems designed by organized medicine itself. Under this "fee-for-service" model, hospitals and doctors set their own "reasonable and customary" fees, and the Blues paid them, rarely asking any questions.

The seeds of Medicare's cost explosion were sown the day Congress embraced fee-for-service reimbursement plans as the model for Medicare. For years, Medicare also asked few questions.

But in the early 1980s, Medicare stopped payment on the blank checks it had given hospitals. Instead of hospitals telling Medicare what their reasonable costs were, Medicare told hospitals what it would pay for a given diagnosis. Almost all hospital services now fall into one of 477 diagnostic-related groups (DRG's), and hospitals are reimbursed according to the diagnostic group for which a patient was admitted. A hospital usually receives a fixed dollar amount for a given diagnosis no matter how long a patient stays.

To some extent, the DRG schedule has slowed the growth in expenditures for hospital claims, since hospitals can no longer automatically pass on their costs to Medicare. But Medicare has been unable to cut costs for physicians' services to the same degree.

In the last five years, Medicare's costs for doctors alone have doubled, growing 40 percent faster than the economy as a whole. That makes the medical-insurance part of Medicare one of the Government's fastest-growing nondefense programs. Medicare coverage for doctors' bills will cost more than $30-billion this year, and spending per beneficiary is growing about 15 percent each year.

Not only have physicians proved adept at increasing their fees (see box, page 3), they may also charge Medicare patients any amount they wish above Medicare's allowable fee, up to certain Government-regulated maximums.

"Excess" physicians' fees today represent one of the biggest gaps in Medicare coverage—coverage that was never intended to pay for everything. Medicare beneficiaries also pay deductibles and coinsurance as well as excess charges. Knowing how these work is the key to understanding coverage under Medicare—and the key to choosing a supplemental insurance policy that plugs the gaps it leaves.

Beyond Medicare lies the need for supplemental insurance. The main gap to cover? Doctors' bills higher than the Medicare "allowable" charge. Plans offered by Blue Cross and Blue Shield and by the AARP fail to cover that gap well.

WHAT INSURANCE DO YOU NEED?

At the heart of Medicare's payment scheme is the "allowable charge." Medicare looks at the actual bill for a particular service and determines the allowable portion that the Government approves for coverage under the program. For hospital services, Medicare pays 100 percent of the charge; in other words, it picks up a patient's entire bill except for a deductible. For most physicians' services, it pays 80 percent; beneficiaries pay the remainder, plus any physician's fee in excess of the allowable charge. That portion of the allowable charge beneficiaries pay is called "coinsurance."

Beneficiaries must also pay deductibles, which are subtracted from the allowable charge before Medicare determines its 80 percent payment.

The particular deductibles, coinsurance, and excess charges depend on the type of service Medicare covers. Part A benefits pay for hospital and related services and are the most comprehensive. Part B benefits cover doctors' fees, various outpatient services, medical laboratory fees, ambulance services, and outpatient psychiatric care. Part B contains the most gaps for supplemental insurance to fill.

Part A: Small gaps in hospital charges

The Catastrophic Coverage Act passed by Congress last year greatly simplified Medicare's hospital coverage. Until this year, the program required beneficiaries to pay coinsurance for certain hospital stays. Now none is required. Except for one annual deductible ($560 in 1989) paid by beneficiaries who need hospital services, Medicare picks up the entire bill, including the cost of semiprivate rooms, lab tests, X-rays, nursing services, meals, drugs provided by the hospital, medical supplies, appliances, and operating and recovery rooms.

There is an additional deductible for blood transfusions. Medicare covers the entire cost of replacing the blood (a requirement at some hospitals), but only after a patient uses three pints. Patients can either pay the replacement costs for the first three pints or arrange to have the blood replaced.

Skilled-nursing coverage. Medicare imposes strict eligibility requirements for skilled-nursing benefits. (Skilled-nursing care is defined as care prescribed by a doctor and available 24 hours a day.) It pays only if care is provided in a Medicare-approved facility; if a doctor certifies that such care is needed daily; and if the facility accepts the patient.

Patients eligible for coverage pay $25.50 each day for the first eight days of a stay. (This coinsurance payment will increase in future years.) Medicare then picks up the entire tab for such things as semiprivate rooms, meals, nursing services, medical supplies, and appliances, but only for 150 days. After that, patients who still need skilled-nursing care are on their own. Medicare pays for less than 2 percent of all nursing-home costs.

Home health-care coverage. There are also strict eligibility rules for home-health benefits. Medicare pays if care is provided by a Medicare-certified home health-care agency; if a patient requires intermittent skilled-nursing care, physical or speech therapy; if a patient is homebound; and if a doctor orders and regularly reviews such care. The benefit lasts as long as Medicare's coverage criteria are met.

Medicare pays 100 percent of the bill for occupational and physical therapists, medical supplies, medical social services, and the part-time services of home-health aides. But if a beneficiary needs medical equipment at home (oxygen or a hospital bed, for example), Medicare pays only 80 percent of the allowable charge for the equipment.

Hospice coverage. For terminally ill patients who choose care in a Medicare-certified hospice, Medicare pays all expenses for nursing and doctor services, supplies, appliances, social services, counseling, home-health and homemaker services. It also pays for pain-relief drugs, but the patient must pay 5 percent of the cost or $5, whichever is less.

This year, hospice benefits are available as long as a physician certifies the patients as terminally ill.

Psychiatric coverage. For those who need psychiatric care in a hospital, Medicare pays the entire cost less a $560 deductible. Coverage, however, is limited to 190 days of care for a patient's lifetime. After benefits run out, patients pay for additional care.

Part B: Big gaps in doctors' charges

Doctors are paid in a way that is confusing to beneficiaries and costly to the program. Here's how Medicare determines allowable charges for most Part B claims:

When a doctor submits a claim, the private insurance companies that process the claims for Medicare compare the bill submitted with the doctor's customary charge and with the prevailing charge in the community for the particular service. The lowest of the three becomes the allowable charge on which Medicare bases its payment.

Figuring the doctor's customary charge and the prevailing charge is a mind-boggling, if not a computer-boggling, exercise. For example, Empire Blue Cross and Blue Shield processes about 25 million pieces of information in its computers to determine the allowable charges for doctors in the 16 counties of New York that it serves.

Allowable charges for the same service may be different for each beneficiary, depending on the doctor's location and his or her billing practices. Not only are there regional differences, but allowable charges may vary among doctors within the same city. There's no standard or national reimbursement rate.

Under this system, it's not hard to see why Part B claims have propelled Medicare's costs into the stratosphere. Doctors continue to raise their charges for both Medicare and non-Medicare patients. Those are then cycled into both the customary and prevailing charges. And those in turn become the bases for the Medicare-allowable charge.

Medicare further gives doctors the option of accepting the allowable charge as payment in full or requiring the patient to pay the difference between the allowable and the actual charge. That gap is the excess charge.

Many doctors bill excess charges. According to the insurance companies whose policies we rate this month, such charges averaged 37 percent more than Medicare's allowable charge in late 1988. Since a patient will pay the deductible (a maximum of $75 per year), 20 percent of the allowable charge, and all of the doctor's fees in excess of the allowable charge, it's easy to see how a person might have to pay well over one-third of the medical bill out of his or her own pocket.

A doctor who agrees to accept the allowable charge all the time is called a "participating" physician. In Medicare parlance such a physician "accepts assignment." Doctors who don't are called "nonparticipating" physicians.

Only about one-third of all doctors are participating physicians, accepting assignment regularly. The rest may accept assignment only when they believe a patient cannot pay the extra charges. In effect, then, doctors are free to provide their own "means test" to patients, accepting the allowable fee for some and billing others a higher fee.

The likelihood of your doctor accepting assignment depends on where you live, the doctor's specialty, and your age. Massachusetts requires all medical doctors to accept the Medicare allowable charge as payment in full. But in Wyoming, which has no such requirement, only 18 percent of the state's physicians are participating doctors. Psychiatrists and nephrologists are more likely to accept assignment than anesthesiologists, surgeons, and general practitioners. And doctors are more apt to take assignment from patients who are

85 than from those who are 65.

About one-quarter of all Medicare Part B claims involve some excess charges, and these charges continue to mount. In 1975, excess charges cost Medicare beneficiaries $500-million. By 1987, the cost had risen to $2.7-billion, an average of $8200 for each nonparticipating medical practice.

Medicare beneficiaries pay one $75 deductible each year for all Part B services. A patient can meet the deductible requirement in one visit to a doctor or by using a combination of services. For most of the following Part B services, Medicare pays 80 percent of the allowable charge; beneficiaries pay the remaining 20 percent. There are exceptions that we note.

Doctors' fees. Part B benefits cover services furnished in a doctor's office or a patient's home and those provided to beneficiaries as hospital inpatients or outpatients. Services include anesthesia, radiology, pathology, surgery, some podiatric treatment, second-opinion consultations, dental care if it involves jaw surgery or setting broken jaw or facial bones, and one specific kind of chiropractic treatment.

In addition to the 20 percent coinsurance, beneficiaries are also responsible for any excess charges. Suppose, for example, a surgeon not taking assignment charges $2000. Medicare determines the allowable charge is $1400. The $600 difference not covered is the excess charge. The patient pays 20 percent of the allowable charge, or $280, plus the $600 excess charge, for a total of $880, assuming the deductible has been paid.

In 1990, the Catastrophic Coverage Act will limit the total amount of *allowable* charges beneficiaries are required to pay. Beneficiaries now are on the hook for unlimited

UNBUNDLED SERVICES AND "CODE CREEP"

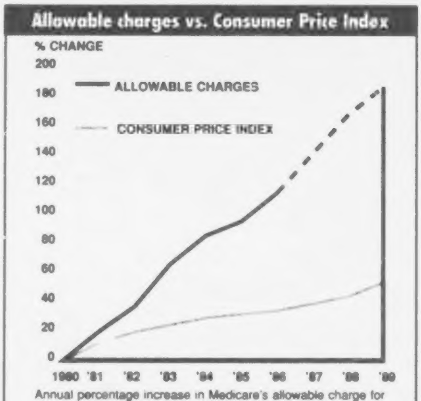
HOW DOCTORS BOOST THE COST OF MEDICARE

Physicians may charge Medicare patients more than the "allowable" fee, up to maximums established by Medicare. According to insurance companies whose policies we rate this month (June 1989), 49 percent of providers charge the companies' policyholders more than Medicare's allowable fee.

Although Medicare has tried to control costs by setting maximums on "excess" charges, thus limiting what it will pay for certain procedures, cost increases are built into the system.

The allowable charge itself takes into account the "customary" and "prevailing" fees in the doctor's practice and in the community. But over the past 10 years, about half the increase in payments to physicians resulted not from direct fee increases but from increases in what's called "volume" and "intensity."

Volume refers to the number of services performed. Not only are doctors performing more procedures, they are now "unbundling" the fees for those services—that is, billing separately for services that were once billed, or "bundled," together. A doctor who once charged an inclusive fee for, say, an office visit and a Pap smear, might now bill separately for each. The therapeutic goal may be the same, but the total fee may be higher.



Annual percentage increase in Medicare's allowable charge for physicians' services per beneficiary. Includes increases due to volume and intensity as well as price (see story).

Sources: Bureau of Labor Statistics and 1988 annual report of the board of trustees of the Federal Supplementary Medical Insurance Trust Fund.

Intensity refers to shifts from less costly services to more expensive ones. It's possible to stretch out an office visit, for example, or to substitute expensive colonoscopy for a less expensive barium-enema X-ray.

The development of numerical billing codes (there are some 7300 of them, representing all physicians' services) has also made it easier for doctors to bill for a more expensive procedure. For example, a doctor can bill a new patient for an office visit using any one of five codes. There's a code for "brief service," "limited service," "intermediate service," "extended service," and "comprehensive service." There may be little difference in the time spent on a limited visit and on an intermediate one, but the intermediate visit usually costs Medicare more money. This phenomenon is called "code creep."

Some of these represent new technologies offering real value to patients, but many are merely add-ons that accomplish the same medical goal. Others represent changes in billing practices that define the same treatment to include more services. And still others may afford no effective treatment at all.

Congress is considering a fee schedule for doctors based on the relative value of the various services performed. The idea is to make fees among physician specialties more equitable and perhaps cut those fees as well, although some health-policy experts doubt such a schedule would curb increases in volume and intensity.

With the options doctors have for raising their incomes, controlling the costs of the Medicare program may be difficult, if not impossible, in a fee-for-service payment system.

But if ways are not found to stem these increases and the Treasury refuses to bear more of the burden, the explosion in Part B expenditures, whether from fee increases or from billing schemes, will ultimately shift more of the cost to patients. Consumers would thus be forced to buy more extensive supplementary insurance or risk what Medicare was intended to avoid—medical costs that destroy the savings they had so carefully put away.

amounts of coinsurance, but in 1990 they will pay no more than $1370 for the year (including the deductible). That number will be adjusted annually.

The new law, however, does not address excess charges. Patients must still dig into their pockets to pay them, and these excess charges will not count toward the $1370 cap. Thus, excess physicians' charges are the single most important gap in Medicare, and the one most necessary to fill with supplemental insurance.

Outpatient hospital coverage. Part B benefits pay for outpatient-hospital services, including those required in an emergency room or outpatient clinic. The cost of blood transfusions is also covered, but the deductible is different from the blood deductible under Part A. If a patient uses three pints and has paid the $75 yearly deductible, Medicare picks up the tab for 80 percent of the allowable charges. Patients are responsible for the 20 percent coinsurance plus replacement costs for the first three pints of blood used.

Physical, occupational therapy. For patients who need these services, Medicare requires that doctors must prescribe a treatment plan and periodically review it. If therapy is provided in an outpatient hospital facility or skilled nursing facility or by a home-health-care agency, clinic, or Medicare-approved rehabilitation agency, Medicare pays its usual 80 percent of allowable charges, and beneficiaries pay the remainder. But if patients receive such therapy from a Medicare-certified therapist who practices independently, the amount Medicare pays is limited to $400 a year.

Psychiatric coverage. Medicare pays benefits for care in either a doctor's office or outpatient hospital facility. For the facility's charge, the usual cost-sharing applies. For the doctor's charge, a special payment formula results in Medicare paying about 62 percent of the allowable charge, up to a maximum payment of $1100.

Laboratory fees. Medicare pays 100 percent of the allowable charge for clinical diagnostic tests (such as for blood and urine) performed in independent laboratories certified by Medicare. If you have tests done in a noncertified lab, you'll have to pay for them yourself. Neither laboratories nor doctors who perform clinical lab tests in their offices can bill beneficiaries for excess charges. For other diagnostic tests such as X-rays, EKGs, and tissue biopsies, Medicare's usual cost-sharing applies, and nonparticipating physicians can bill patients for amounts higher than the Medicare-allowable fee.

Ambulance services. Medicare has special rules for ambulance services. Patients must have a medical reason for needing an ambulance; the ambulance and its equipment must meet Medicare's requirements; and transporting the patient in another vehicle could endanger his or her life. If those conditions are met, Medicare pays 80 percent of the allowable charge; beneficiaries pay the remaining 20 percent.

Drugs. Currently, Medicare pays only for drugs while a beneficiary is in a hospital or skilled nursing facility; for injections in physicians' offices; and for immunosuppressive drugs a patient needs for one year following a Medicare-approved organ transplant (subject to Part B deductibles and coinsurance).

In 1990, patients who have undergone non-Medicare-approved transplants or who are in their second year following a transplant that Medicare has approved must pay a $550 deductible and 50 percent of the allowable charges for immunosupressive drugs. If a person needs home intravenous antibiotic drugs, he or she must also pay a $550 deductible plus 20 percent of the allowable charges.

In 1991, the Catastrophic Coverage Act provides coverage for all prescription drugs (including those used after organ transplants and home-intravenous antibiotics), subject to a large deductible ($600) and large coinsurance amounts (50 percent for all except home intravenous antibiotics).

What's not covered

Medicare doesn't pay for in-hospital private-duty nurses or for private rooms in hospitals or skilled-nursing facilities unless such rooms are medically necessary. Neither does it pay for TVs, telephones, and other personal items.

In general, it pays only for services that are reasonable and medically necessary. A beneficiary can't submit a claim for setting a broken arm and then bill Medicare for a chest X-ray, too, unless the doctor found a clinical reason for the X-ray. Nor does the program pay for preventive care such as routine annual physicals, except for mammographic screening beginning in 1990.

With few exceptions, the program does not pay for immunizations, nor does it pay for insulin injections that patients can administer themselves. It doesn't pay for routine foot care, dental care, eyeglasses, and hearing aids and the examinations required for fitting and prescribing each. Virtually all chiropractic services and cosmetic-surgery procedures are not covered.

There are no benefits for long-term skilled care in nursing homes beyond 150 days, for custodial care that helps people cope with activities of daily living such as eating and bathing, or for meals delivered to a person's home.

If beneficiaries become sick while visiting foreign countries, they can't look to Medicare to cover their expenses. Medicare pays for treatment only in some Canadian and Mexican hospitals in some unusual situations.

Recapping the gaps

With the new catastrophic benefits, the gaps in Medicare coverage have narrowed. Except for the deductible, which rises annually, virtually all of an elderly person's hospital expenses are paid by Medicare and, after 1989, the amount of coinsurance required under Part B will be limited. Were it not for excess charges, a beneficiary's hospital and medical expenses would be limited to about $2000 a year—$1370 for the Part B deductible and coinsurance, and $560 for the Part A deductible, plus any drug deductible. But if your physician bills for excess charges, as many do, or if you need a team of specialists who bill for excess charges, your out-of-pocket expenses could be far greater.

In 1989, a typical beneficiary will pay some $668 for Medicare coverage (including the basic and the supplemental premium), a relative bargain considering what Medicare spends—an average of $2800 a year for each beneficiary.

How much, if any, supplemental insurance to buy is a decision each Medicare beneficiary must make. The report on page 5 will help you make that decision. ■

WHICH POLICIES ARE BEST?

Medicare was never meant to cover the entire health bill for the elderly. In the early days, the gaps left by Medicare were small—and so was the premium for supplemental policies. But as health-care costs exploded, the gaps widened, and the amount spent on Medicare-supplement insurance became a major item in the budgets of the elderly.

The most generous of the policies we rated for this report would cost a senior citizen about $1000 a year. The Best Buy policies, somewhat less comprehensive, would cost about $600 a year.

Unfortunately, some elderly people are talked into buying two or more policies. Spurred by commissions as high as 70 percent of the first-year premium, agents have convinced some people to buy policies that duplicate coverage they already have and to switch frequently from one Medicare supplement to another. Some companies told us that as many as 35 percent of their policyholders drop their coverage during the first year, presumably for a competitor's brand.

There are large differences in quality among Medicare-supplement policies as well as large differences in price. Many are comprehensive, covering nearly all the remaining gaps; others cover only a few. And some policies provide far better benefits than others at a far lower premium.

Together, policies sold by Blue Cross and Blue Shield organizations and by the American Association of Retired Persons (AARP) represent more than half of all supplemental insurance sold. Yet our study found that, for the most part, the Blues and the AARP are selling relatively mediocre policies. As the Ratings on page 8 show, many of the best policies come from less-well-known companies.

Covering the hospital gaps

There's little difference among policies when it comes to filling the Part A gaps. Indeed, insurance regulators require that policies cover either all or none of the biggest gap, the $560 hospital deductible. Every policy in our study covers the deductible.

Policies must also cover the coinsurance payment of $25.50 a day for the first eight days of care in a skilled-nursing facility, but they don't have to offer coverage after the 150th day, when Medicare stops paying the bills.

Here, differences among policies emerge. Many pay nothing after 150 days; others provide coverage ranging from generous to skimpy. Colonial Penn, for example, pays 100 percent of the national average daily charges, subject to a maximum of $100,000, but Blue Cross and Blue Shield of Massachusetts pays a meager $10 a day.

Note that neither Medicare nor Medicare-supplement policies pay for custodial or intermediate care, the type of care elderly people are most likely to need. (One policy offered by Pyramid Life does cover stays in intermediate-care nursing homes.) Usually, though, you need to buy separate insurance for long-term nursing-home care, (see CONSUMER REPORTS, May 1988.)

Covering the medical gaps

Part B coverages separate the sheep from the goats in the field of supplemental policies. A surprising number of policies pay neither the $75 Medicare Part B deductible nor anything toward excess physicians'

WHAT AN INSURANCE PACKAGE COSTS

PLAN TO SPEND $2000 TO $3000

Medicare's hospital (Part A) benefits are financed solely out of Social Security payroll taxes. The Medicare portion of Social Security taxes flows into a separate trust fund earmarked for payments to hospitals.

Medicare's medical benefits (Part B) are financed from general tax revenues and by the beneficiaries themselves. Part B coverage is optional for those 65 and older. Those who elect coverage pay in 1989 a basic monthly premium of $27.90 (this premium rises annually).

The Catastrophic Coverage Act requires beneficiaries to pay an additional amount on top of the basic premium. In 1989, that amount is $4 per month, bringing the total monthly premium to $31.90. In 1990, they will pay $4.90 extra; and in 1991, $7.40 more. The basic premiums are usually deducted from monthly Social Security checks.

The Act imposes an additional tax called a "supplemental premium" on all those eligible for Medicare benefits, whether or not they've chosen coverage under Part B. The premium is a surcharge on a beneficiary's Federal income taxes. In 1989, the surtax is $22.50 for each $150 of Federal taxes due, up to a maximum of $800 per individual.

In 1989, the average supplemental premium is expected to be $285, with only one-third of those 65 and older paying any at all. Only 5 percent (those with the highest incomes) will pay the maximum.

The table below shows how much a 65-year-old retiree should set aside to pay for health insurance in 1989. A person could easily spend between $2000 and $3000 for all health-insurance coverages, depending on the supplemental-premium tax and the price of both the Medicare-supplement and long-term care policies. Older retirees could pay more, since many insurance companies charge them higher premiums for these coverages. The average-cost package assumes a person would pay the average Medicare-supplemental premium this year and buy average-priced insurance policies. The high-cost package assumes a retiree will pay the maximum supplemental tax and can afford higher-priced policies. Everyone who enrolls in Medicare Part B pays the same basic premium regardless of income.

Items to budget	Average-cost package	High-cost package
Medicare Part B basic premium	$ 383	$ 383
Medicare supplemental premium	285	800
Supplemental insurance policy	635 [1]	987 [2]
Long-term care insurance policy	642 [3]	918 [4]
TOTAL	**$1945**	**$3088**

[1] *The annual premium for policy from Golden Rule, a Best Buy in our Ratings.*

[2] *The annual premium for the top-rated Bankers Life and Casualty policy.*

[3] *The annual premium for the high-rated Bankers Life and Casualty policy with home-health care rider fro our May 1988 report on long-term care insurance.*

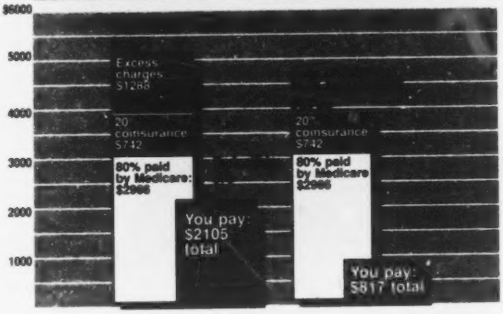
[4] *The annual premium for the high-rated John Hancock policy from our May 1988 report.*

charges, the most likely source of big out-of-pocket expenses. Many policies pay only the 20 percent coinsurance for the allowable charge.

Most plans sold by Blue Cross and Blue Shield organizations are these so-called 20 percent policies. A bare-bones 20 percent policy is also the best-selling plan in the insurance portfolio of AARP. While AARP does sell more generous plans, half of its policyholders opt for the 20 percent plan.

Through the years, AARP has advised its members to buy a minimum of insurance against doctors' bills and to seek out physicians who "participate" in Medicare—that is, physicians who have committed themselves to accept Medicare's allowable charge as payment in full all the time. We think that's unrealistic advice. Most physicians are not participating. Even if you find a family doctor who does accept assignment, an illness may require a team of medical and surgical specialists, at least some of whom are probably "nonparticipating." Finally, many people who reach Medicare age have long-established relationships with physicians and prefer not to bargain-hunt for new ones.

Anatomy of a claim



The graph above shows the breakdown of the actual claim we used to determine the Part B gap for the policies we rated. We also show the same claim assuming all medical providers accepted assignment.

We gave preference in our Ratings to policies that cover excess physicians' charges.

The percentage game

Policies that do cover excess charges cover them in different ways, creating great confusion for anyone trying to compare policies. The excess charge a policy pays is not always the same as the excess charge the doctor bills.

Insurers first define what they mean by excess charge for the purpose of calculating payment. Typically, they define an excess charge not as what the doctor may actually bill in excess of the allowable charge but as the excess charge up to a fixed percentage of the allowable charge. Standard Life and Accident, for example, says an excess charge is any charge up to 80 percent higher than the allowable charge. Other companies define an excess charge as any charge the company deems reasonable and customary. And still others use both limitations.

A policy may then further restrict its payment to a stated percentage of what it has defined as an excess charge. It may pay as much as 100 percent of what it says is an excess charge, or it might pay less. It may also make its payment for excess charges subject to a deductible.

It's easy to see how agents' sales pitches and promotional materials can create confusion by playing word games with the definition of excess charges. The claim most often made is that a policy pays 100 percent when, in fact, it pays considerably less than 100 percent of the actual bill.

Of the policies we examined, only the plan of First National Life was a true 100 percent plan, one that pays all excess physicians' charges.

Other features

Most companies tack a variety of features onto their basic coverages, hoping that one or two will distinguish their offerings from competitors'. These extras might include coverage for prescription drugs, care in a skilled-nursing facility not certified by Medicare or care in foreign countries. Some of these features are more valuable than others.

Foreign travel benefits are important if you plan to roam the world during retirement. But beware: Benefits vary greatly. Some policies offer no coverage unless Medicare pays; but, as we point out on page 4, Medicare rarely pays. Blue Cross and Blue Shield of Massachusetts pays the same benefits in a foreign country that it would pay in the U.S. plus the part Medicare would have paid. AARP offers limited coverage in foreign countries only for medical emergencies and accidents.

The Blue Cross plans, which tend to be deficient in the major coverages, often throw in a package of extras that at first blush seem more useful than they are. For the most part, we considered them frills.

For example, Blue Cross and Blue Shield of Massachusetts covers the services of a midwife, services a senior citizen is likely to use only in the case of a truly blessed event.

Blue Cross and Blue Shield of Maryland includes discount coupons, but we wouldn't recommend that anyone buy this policy to receive 20 cents off a package of *Dr. Scholl's* corn cushions or 85 cents off a box of *Depend* undergarments.

Blue Cross and Blue Shield of Colorado had the best package of features, offering valuable coverage for routine physicals and for vision and hearing examinations.

First National Life and Equitable Life and Casualty add accidental death benefits. If policyholders die in an accident, an unlikely event for older people, First National will refund the premiums; Equitable will pay a maximum of $5000 to a policyholder's beneficiary.

What's not covered

In general, policies pay only for the type of services Medicare covers. If Medicare doesn't pay for something, it's unlikely the policy will pay.

Some policies restrict coverage even more. Typically, the Blue Cross plans are the most restrictive: Blue Cross and Blue Shield of Tennessee, for example, lists 22 limitations and exclusions, including no coverage for removal of corns and callouses, or for "travel," whatever that means.

In contrast, Colonial Penn's policy has only one exclusion—no coverage for war injuries.

Many policies exclude coverage for mental and nervous disorders, although some are fussier than others. Pyramid Life excludes coverage for mental or emotional disorders, alcoholism, and drug addiction. AARP's plan is more liberal, excluding hospital coverage for mental, psychoneurotic, and personality disorders unless Medicare covers them.

Most policies also require a waiting period before they will cover you for those health conditions you have at the time the policy is written. Policies prescribe how long you must have had such a condition for the waiting period to apply. Some define a pre-existing condition as any ailment diagnosed within the last six months; others say the last three months.

The waiting period before coverage for pre-existing conditions begins is usually one to six months.

Surprisingly, a few companies offer coverage from day one for any health condition, and a few others allow policyholders to buy riders to shorten the usual waiting period. If you have a serious health condition, a policy with a shorter waiting period might be worth the small extra cost. For example, First National Life makes a one-time charge of $59.71 to shorten the waiting period from six months to one month. (The policy we rated did have this rider.)

Are you a good risk?

Many companies don't require physical examinations or doctors' statements before issuing the coverage. In fact, about half the companies represented in our survey, mostly Blue Cross organizations and AARP, take all comers, no questions asked. But many of the Blue plans offer policies with numerous restrictions and limitations.

Other companies are choosier, requiring applicants to meet certain standards. Rejection rates vary. Colonial Penn rejects less than 1 percent of all applicants while National Home Life turns down between 10 and 15 percent.

Golden Rule has the toughest standards, rejecting 20 to 30 percent of all applicants who are 65, and as many as 50 percent of those who are 70. "We look for the healthy risks," says Susan Puorro, a company marketing executive.

A few companies let their agents "underwrite" the policies. The agent will ask a few questions about your health; if your answers reveal serious problems, the agent won't even take the application.

A look at the premium

With many policies, the price you pay depends on your age. The older you are, the higher the premium, since you're more likely to need the coverage. Other policies, such as those from most Blue Cross and Blue Shield plans and AARP, charge "community rates"—everyone pays the same regardless of age.

No matter what the premium is when you buy the policy, it's likely to increase. Yearly rate increases are common.

Members of Congress who supported the Catastrophic Coverage Act in 1988 had high hopes for a reduction in premiums for Medicare-supplement policies, since some of the costs had been shifted from the private-insurance system to Medicare. But that hasn't happened. Companies did eliminate the duplication in coverage between their policies and the improved Medicare coverages, but many then petitioned state regulators for rate increases, pleading that the ever-increasing costs of medical care outstripped any savings realized from the Catastrophic Coverage Act.

A few state regulators have begun to take a hard look at premiums to see if they're too high. They are scrutinizing loss ratios, a rough measure of a policy's premiums in relation to the benefits paid out, and finding them too low. In some states, regulators have denied rate increases if loss ratios were too low, but in others, companies have had carte blanche to charge what they wish.

Can it be canceled?

Eleven of the policies in our study cannot be canceled; in effect, they are guaranteed renewable for the life of the policyholder, a highly desirable provision. Others are conditionally renewable. That means the company can cancel the policy but must do so for all policies in the same class—for example, all policies in a particular state.

A few companies, though, can cancel any individual's policy without regard to similar policies. California Blue Cross can cancel any policy with 30 days' notice. Blue Cross and Blue Shield of Maryland can cancel whenever it wants unless a policyholder is about to go to the hospital.

Rating the policies

We asked 53 companies to send us information about their new policies, those written to supplement Medicare as amended in 1988 by the Catastrophic Coverage Act. The U.S. General Accounting Office had identified these companies as the biggest players in the market. Twenty-five

AARP and its insurance carrier, Prudential, which has the second largest share of the Medicare-supplement market, raised premiums across the country an average of 40 percent. If it hadn't been for the Catastrophic Coverage Act, premiums would have increased even more, says an AARP official.

THE TOP-RATED PLANS

WHERE THEY ARE SOLD

This table lists the 10 top-rated plans and the states where they are sold. A company may be awaiting approval to sell this policy in states other than the ones listed here.

Company/Plan	Where sold
Bankers Life & Casualty Planned Insurance Coverage (GR-A002)	All states but New York.
Pioneer Life New Ultimate Protector (IMP-9161 (Rev. 11/88)-G)	Ala., Alaska, Ariz., Ark., Calif., Colo., Del., D.C., Fla., Ga., Hawaii, Idaho, Ill., Ind., Iowa, Kan., Ky., La., Miss., Mo., Mont., Neb., Nev., N.H., N.M., N.C., Ohio, Okla., Ore., Pa., S.C., S.D., Tenn., Tex., Utah, Vt., Va., Wash., Wis., Wyo.
Standard Life & Accident Medicare Supplement Policy (1232-1/89)	Ala., Ariz., Ark., Calif., Colo., Fla., Ga., Hawaii, Idaho, Ill., Ind., Iowa, Kan., Ky., La., Miss., Mo., Mont., Neb., Nev., N.M., N.C., N.D., Ohio, Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Va., Wash., W. Va., Wyo.
Golden Rule Medigap Plus (GR1-H-12P)	Ala., Ark., Colo., Del., Fla., Idaho, Ill., Ind., Iowa, Ky., La., Maine, Mich., Miss., Mo., Nev., N.H., N.M., Ohio, Okla., S.D., Tenn., Tex., Utah, Va., Wyo.
Prudential, AARP AARP's Comprehensive Medicare Supplement (M7 FLA 1-89)	All states.
Pyramid Life Medicare Supplement (G-15)	Ala., Ariz., Ark., Calif., Colo., Del., Ga., Idaho, Ill., Ind., Iowa, Kan., Ky., La., Md., Minn., Miss., Mo., Mont., Neb., Nev., N.M., N.C., N.D., Ohio, Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Va., Wyo.
Colonial Penn Medicare Supplement Policy (4-82-594(09))	Ala., Ariz., Calif., Colo., Fla., Ga., Ill., Ind., Iowa, La., Mich., Mo., Neb., Nev., N.M., N.C., N.D., Ohio, Ore., Pa., S.D., Tenn., Tex., Va., Wis.
First National Life Medicare Supplement Policy (MS-189)	Ala., Alaska, Ariz., Ark., Colo., Del., Fla., Ga., Idaho, La., Md., Miss., Mont., Neb., Nev., N.M., Okla., Ore., S.C., Tenn., Tex., Utah, Wyo.
National Home Life Secure Care Preferred (NH-121-189FL(L))	Filing for approval in all states except Ky., Mass., Md., Mich., Minn., Wis.
Equitable Life & Casualty The New Ultimate (880) (89)	Alaska, Ariz., Ark., Colo., Hawaii, Idaho, Ill., Ind., Ky., La., Miss., Mo., Mont., Neb., Nev., N.M., N.D., Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Wash., Wyo.

companies representing some 80 percent of the market sent us their most popular plan.

Many have other policies that offer more or less coverage than the one the company expects to generate the most sales. Since coverage for excess charges is so important, we also rated excess-coverage policies available from AARP, Mutual of Omaha, and Blue Cross and Blue Shield of Florida, even though they might not be heavily sold.

We determined a number of features that a good policy should have and assigned points to each, giving the most weight to how well the policies filled the remaining Part A and B gaps.

For Part A, our gap was hypothetical, based on the cost of hospital rooms in St. Petersburg, Fla., the cost of private-duty nurses, blood transfusions, skilled-nursing facilities, psychiatric hospitals, and supplemental hospice and home-health care.

For Part B, we used an actual claim submitted by a man who had fallen and needed complicated hip-replacement surgery. The medical bills totaled $5071. Medicare left $2105 uncovered.

The Part B out-of-pocket expense noted in the Ratings is our estimate of the cost remaining after each rated policy kicked in. (The claim also included a small prescription drug expense.) These out-of-pocket expenses ranged from zero for the policy of First National Life to $1467 for the Prudential plan most often sold by AARP.

We also looked at coverage for such things as care in foreign countries or for prescription drugs, and gave credit if the policy offered those extras.

We judged whether policies had too many exclusions and limitations, whether they were renewable for

RATINGS

Medigap policies

Listed in order of estimated overall quality. Except where separated by bold rules, differences between closely ranked plans were minor.

1 **Monthly premium.** This is the monthly premium for a 65-year-old woman living in St. Petersburg, Fla. For a company not doing business there, the premium is for the main area where it operates.

2 **Part A.** Refers to hospital coverage each policy provides. It can include payment of Medicare's $560 **deductible** and benefits for **private rooms** and **in-hospital private nurses**, the **skilled-nursing-home copayment** for the first eight days, and coverage for **skilled nursing beyond 150 days**.

3 **Part B.** Refers to medical coverage offered by each policy. It can include payment of Medicare's **$75 deductible**, coinsurance

Company	Policy	Telephone number	1 Monthly premium
Bankers Life and Casualty	Planned Ins. Coverage (GR-A002)	800-777-5775	$82.25
Pioneer Life	New Ultimate Protector (IMP-9161 (Rev. 11/88)-G)	800-752-4368	75.64
Standard Life and Accident	Medicare Supplement Policy (1232-1/89)	405-232-5281	73.24
Golden Rule, A Best Buy	Medigap Plus (GR1-H-12P)	317-297-4123	52.91
Prudential, American Assoc. of Retired Persons	AARP's Comprehensive Medicare Supplement (M7 FLA 1-89)	800-523-5800	110.50 [6][11]
Pyramid Life	Medicare Supplement (G-15)	913-722-1110	71.93
Colonial Penn	Medicare Supplement Policy (4-82-594(09))	800-523-4000, ext. 49	89.57
First National Life	Medicare Supplement Policy (MS-189)	800-289-3654 800-999-2224	85.00
National Home Life, A Best Buy	Secure Care Preferred (NH-121-189FL (L))	800-356-6271	47.95 [4]
Equitable Life and Casualty	The New Ultimate (880) (89)	800-633-3480	64.42
Blue Cross and Blue Shield of North Carolina	Plan 12 (Plan 12 K-999 1/89)	800-222-4816	59.04 [6]
Community Mutual Blue Cross Blue Shield (Cincinnati)	Mediplus (PD 003)	800-367-5892	51.37 [6][20]
United American	United American Medicare Supplement Plan (MC3 AB)	214-328-2841	84.00
Blue Cross and Blue Shield of Florida	Medicare Supplement P(VI) (7555-287)	904-354-3331 800-876-2227 East of Mississippi River	105.30
Blue Cross of Western Pennsylvania w/Penn. Blue Shield	65 Special and 65 Plus and Blue Shield 65 Special Agreement (65-Plus - DL (10/88))	412-255-7349	61.75 [6]
Blue Cross and Blue Shield of Colorado	Senior Preferred Individual Coverage	303-831-2043	88.80 [9]
Capital Blue Cross w/Penn. Blue Shield (Harrisburg)	65-Special Subscription Agreement	717-255-0820	45.75 [6][10]

life, and whether their pre-existing conditions clauses were particularly onerous. We also noted rejection rates, lapse rates, clarity of policy language, and major state enforcement actions against companies. (In this regard, the Ratings penalized National Home Life and Colonial Penn, because regulators had fined them for misleading advertising.)

Recommendations

Since the Catastrophic Coverage Act has greatly reduced a retiree's liability for Medicare's copayments, coverage for excess charges from physicians under Part B is a major reason to buy a Medicare-supplement policy. Even though your own physician may accept assignment, many specialists and surgeons don't, so you could still be stuck with a large bill not covered by Medicare.

Many Blue Cross organizations and AARP issue policies to anyone and charge everyone the same rate—desirable and, for some retirees, necessary features. But their best-selling policies didn't fare well on the coverage we considered most important. A policy that's readily available and cheap is no bargain if it doesn't also cover the most important risks.

Unfortunately, many buyers may have few choices other than the local Blue Cross plan, since the best plans are not universally available. Many of the high-rated companies (Bankers Life, Golden Rule, Pioneer Life, and Colonial Penn, for example) do not sell policies in New York, where Blue Cross plans dominate the market. For details on where the high-rated plans are sold, see page 381.

The plans in the top Ratings group all offer excellent coverage to fill the gaps left by Parts A and B of Medicare. They provide generous benefits for excess physicians' charges, leaving only between $75 and $775

◉ ◓ ○ ◒ ●

Better ← → **Worse**.

of **20 percent of allowable charges**, and excess charges. We show **how excess charges are defined**, the **percentage paid**, and the **deductible** that applies, plus **out-of-pocket expenses for our sample claim**.

Other coverages. Additional coverages and features a policy may offer.

Foreign country. Whether a policy pays substantial benefits abroad.

Renewability. A **G** indicates the policy is guaranteed renewable for policyholder's life. A **C** means it's conditionally renewable; a company can cancel all the policies in a particular class.

Pre-existing illness. Indicates how many months policyholders must wait to be covered for illnesses they have at the time policy is issued.

Policy restrictions. Refers to the number and severity of limitations and exclusions in each policy.

Part A: Deductible	Part A: Private room	Part A: In-hospital private nurses	Part A: Skilled-nursing-home copayment	Part A: Skilled nursing beyond 150 days	Part B: $75 deductible	Part B: 20% of allowable charges	Part B: How excess charges are defined	Part B: % paid	Part B: Deductible	Part B: Out-of-pocket expenses for our sample claim	Other coverages	Foreign country	Renewability	Pre-existing illness, mos.	Policy restrictions
✓	—	—	✓	✓	✓	✓	All usual and customary charges above allowable charges	100	0	$ 104	—	✓	G	0	◉
✓	✓	✓	✓	✓	✓	✓	Up to 100% above allowable charges	100	0	104	—	—	G	1	◉
✓	—	—	✓	✓	✓	✓	Up to 80% above allowable charges	100	0	104	—	✓	G	0	◉
✓	—	✓	✓	✓	[1]	✓	All reasonable and customary charges above allowable charges	80	$50 overall	303	A,F	✓	C	6 [2]	◓
✓	—	✓	✓	✓	—	✓	All usual and prevailing charges above allowable charges	100	0	75	A	[12]	[13]	3	◓
✓	—	✓	✓	✓	✓	✓	Reasonable and customary charges up to 50% above allowable charges	100	250	775	S,T	[3]	G	3	◓
✓	✓	✓	✓	✓	✓	✓	Provider's regular charges above allowable charges	100	0	104	C	—	G	3	◉
✓	—	—	✓	—	✓	✓	All charges above allowable charges	100	0	0	A,D,AA	—	G	1	○
✓	—	—	✓	✓	—	✓	Up to 100% above allowable charges	50	0	704	A,U,BB	—	G	3	◉
✓	—	✓	✓	—	[5]	✓	Up to 100% above allowable charges	100	0	104	A,J	—	G	3	○
✓	—	✓	✓	—	—	✓	No coverage	—	—	1348	A,B,G,R	✓	G	6	◒
✓	—	✓	✓	—	✓	✓	No coverage	—	—	1273	A,H,M,O,P	[7]	G	[8]	◓
✓	✓	✓	✓	—	✓	✓	Reasonable and customary charges up to 50% above allowable charges	80	0	673	B	✓	G	2	◓
✓	—	—	✓	✓	✓	✓	Up to 20% above allowable charge	100	0	926	A,B,CC	[16]	C	3	●
✓	—	✓	✓	✓	—	✓	No coverage	—	—	1348	A,N	✓	C	0	●
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,B,K	✓	C	0	◉
✓	✓	—	✓	✓	—	✓	No coverage	—	—	1467	—	✓	C	0	○

Ratings continued on next page

of expenses uncovered for the sample claim we used. These policies were liberal when it came to excluding and restricting benefits once a policy is issued.

Some of the policies in the second group also offer excellent coverage. The eighth-ranked policy, sold by First National Life, offered the best coverage for excess physicians' charges; it didn't place in the top group because it lacked other coverages we thought were important and listed a number of limitations and exclusions (as did several other policies in this group).

Policies lower in the Ratings offer less generous basic coverage and tend to be more restrictive once a policy is issued. Many don't pay the $75 Part B deductible. Note that the best-selling policy of the American Association of Retired Persons is only mediocre. It provides no coverage for excess charges, leaving $1467 of our sample claim uncovered, and does not pay the Part B deductible. The policy is, however, fairly liberal when it comes to exclusions and limitations.

Price, although not factored into the Ratings, is an important consideration in choosing a Medicare-supplement policy. Note that some of the excess plans cost less than many of the 20 percent policies. Someone paying $88.80 a month for a policy from Blue Cross and Blue Shield of Colorado, for example, would be better off with a policy sold by Golden Rule or Pioneer Life with their $52.91 and $75.64 monthly premiums.

The policies from Golden Rule and National Home Life merit a Best-Buy rating, offering policyholders excellent coverage at an attractive price. Golden Rule keeps its price down in several ways. First, it does not pay its agents high commissions to sell Medicare-supplement policies, a good practice in our view. Less desirable from the consumer's point of view is its practice of selling only to healthy people.

Golden Rule may simply refuse to sell you a policy if it suspects you are in poor health, and it won't promise to renew your policy even if it accepts you as a customer. Golden Rule's policy is only conditionally renewable. The company can cancel coverage as long as it does so for an entire class of policies in your state.

The policy from National Home Life is guaranteed renewable and offers good coverage at an excellent price. National Home Life sells its policies through the mail, bypassing agents and the costly commissions other companies must pay.

National Home Life may be familiar because of its association with Art Linkletter, the company spokesman who had appeared in a series of deceptive television commercials. The company appears to have cleaned up its act. Television commercials shown to our reporter were free from the misleading statements of previous offerings.

AARP's excess-coverage plan also offers excellent coverage; its benefits for excess physicians' charges are as generous as the top-rated Bankers

Company	Policy	Telephone number	Monthly premium
Mutual of Omaha	Mutualcare (M115)-Series 15774 with Percentage Plus Option Rider (8545M)	800-228-9999	$68.62 [9]
Prudential, American Assoc. of Retired Persons	AARP's Medicare Supplement Plus (M6 FLA 1-89)	800-523-5800	48.60 [6][11]
Blue Cross of Greater Philadelphia d/b/a Independence Blue w/Penn. Blue Shield	65 Special-Blue Shield 65 Special (5093 1/89) and (66H-9/82)	215-448-3397	54.30 [6]
Blue Cross and Blue Shield of Massachusetts	MEDEX 3 (ME3)	800-258-2226	52.32 [6][10]
Blue Cross and Blue Shield of Florida	Medicare Supplement P(V) (7553-287)	904-354-3331 800-876-2227 (East of Mississippi River)	40.70
Blue Cross of Northeastern Pennsylvania w/Penn. Blue Shield	65-Special Subscriber Agreement and Blue Shield 65-Special Agreement (PRAG-5 1/89) and (66H 9/82)	717-829-8500	47.20 [6]
Mutual of Omaha	Mutualcare (M115)-Series 15774	800-228-9999	43.96 [9]
Blue Cross and Blue Shield of Maryland	65 Choice Plus (3.923)	304-494-6817	65.66 [9][10]
Empire Blue Cross Blue Shield (New York)	Enhanced Medicare Plus (DP-MED.SUPP.HO)	212-490-6868	61.75 [6][10][21]
Blue Cross Blue Shield of Tennessee	Blue Cross 65 Standard Contract (00-0-65 2/87)	615-755-5917	43.66 [6]
Blue Cross of California	Gold Plan (5332 1/87)	800-333-3883	87.00 [10]

[1] *Pays 20% of Part B deductible.*

[2] *Pays for loss due to pre-existing condition that was fully disclosed in the application.*

[3] *Provides for emergency care outside the U.S.*

[4] *First month's premium is $1.*

[5] *Payment subject to one-time $75 deductible.*

[6] *Same rate for all ages.*

[7] *Pays for emergency inpatient and outpatient care outside the U.S., up to a lifetime maximum of 365 days of hospital coverage.*

[8] *Policy does not refer to a waiting period for pre-existing conditions; company claims 6 mos.*

[9] *Premium increases when policyholder reaches higher age bracket.*

[10] *One-third of quarterly premium.*

[11] *Company expects this will be the premium July 1, 1989.*

[12] *Pays for 60 days of covered emergency care; 80% after $50 deductible with a $25,000 maximum.*

[13] *Group policy with individual certificates; other than extension of benefits rights, there are no rights to continue policy if group policy terminates.*

[14] *Pays deductible for outpatient hospital visits.*

[15] *Mass. physicians cannot bill for excess charges.*

[16] *Medical emergency/accident services up to the extent Medicare would have paid.*

[17] *Renewable at company's option unless policyholder has applied for hospital admission.*

[18] *Company can cancel entire class of policies with 5 mos. notice.*

[19] *Company can cancel with 30 days notice before subscription is due.*

[20] *Premium for Cincinnati.*

[21] *Premium for New York City region.*

Life and Casualty policy. But its $110.50 monthly premium makes it the priciest policy in our survey, almost $30 a month more than the Banker's policy. No wonder only 3 percent of AARP's policyholders have bought it. AARP members who want a policy with excess coverage would be better off considering any of a number of other excess-coverage plans in our survey.

Other considerations

Here are some other points to keep in mind when selecting a Medicare-supplement policy:

1. Buy only one policy. The Health Insurance Association of America, an industry trade group, estimates that almost one-fifth of all Medicare-supplement policyholders own more than one. There's no coordination of benefits with these policies; all will pay. But buying more than one is a waste of money. One good policy will cost less and do the job of several inadequate ones.

2. If you're eligible for Medicaid, don't buy a policy. Medicaid takes care of your bills.

3. If your income is low but not low enough to be eligible for Medicaid, consider joining an HMO rather than buying a Medigap policy. The amount you would pay for HMO services could be less than the price of a good supplemental policy.

4. If your former employer provides health insurance for retirees, take it. This coverage supplements Medicare and often pays excess charges. Furthermore, some employers subsidize the cost.

5. Do not buy policies that pay a flat amount for days in a hospital (hospital-indemnity policies), or dread disease and accident policies that pay benefits only if a particular ailment or accident should befall you.

6. If you're older or in poor health, consider a company that charges everyone the same rate and does not scrutinize every health problem prospective policyholders may have. Your premiums are likely to be lower. But be sure that the coverage is adequate. A lower premium isn't much help if the coverage is not what you want.

7. Conversely, if you've just turned 65 and are in good health, a company that charges lower premiums for younger people or one that carefully checks a person's health status may be the one you want. You'll benefit from lower premiums.

8. If your current Medicare supplement does not provide coverage for excess charges, ask your carrier if it offers another plan that does. Compare the cost of its plan with some of the high-rated ones in our survey. The company may waive the pre-existing conditions clause on the new policy if you upgrade your coverage.

9. Shop several agents and companies. Don't look only to your local Blue Cross plan just because it's familiar. Ask agents for the outline of coverage for each policy and compare them. If agents refuse to give you the outline or push only one plan, quickly show them the door. ■

Part A					Part B										
Deductible	Private room	In-hospital private nurses	Skilled-nursing-home copayment	Skilled nursing beyond 150 days	$75 deductible	20% of allowable charges	Pays excess charges as defined	% paid	Deductible	Out-of-pocket expenses for our sample claim	Other coverages	Foreign country	Renewability	Pre-existing illness, mos.	Policy restrictions
✓	—	—	✓	—	—	✓	Reasonable and customary charges up to 50% above allowable charges	100	0	$ 600	C,F	✓	C	6	◓
✓	—	✓	✓	✓	—	✓	No coverage	—	—	1487	—	[12]	[13]	3	◓
✓	✓	—	✓	✓	[14]	✓	No coverage	—	—	1487	—	✓	C	6	◒
✓	—	✓	✓	✓	✓	✓	No coverage [15]	—	—	[15]	A,G,I,L,V,W,X	✓	C	0	○
✓	—	—	✓	✓	—	✓	No coverage	—	—	1461	B	[16]	C	3	●
✓	—	—	✓	✓	—	✓	No coverage	—	—	1467	—	✓	C	6	◒
✓	—	—	✓	—	—	✓	No coverage	—	—	1467	C,F	✓	C	6	◓
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,E	✓	[17]	2	◓
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,Q,Y	✓	[18]	6	●
✓	—	—	✓	✓	—	✓	No coverage	—	—	1467	B,Z	✓	C	6	●
✓	—	—	✓	—	—	✓	No coverage	—	—	1348	A	✓	[18]	6	●

Key to Other Coverages

A–Substantial out-of-hospital prescription-drug benefit.
B–Automatic receipt of claims.
C–Home-health care.
D–Waiver-of-premium benefit.
E–Network of providers for dental, vision, and hearing services offering discounts of 30 to 60 percent.
F–Skilled-nursing care in a facility not approved by Medicare.
G–Chiropractic services beyond what Medicare recognizes, if medically necessary.
H–Therapists beyond those that Medicare recognizes.
I–Enteral formulas, freestanding diagnostic imaging systems.
J–Accidental-death benefit.
K–Package of features includes coverage for prescription drugs, durable medical equipment, oxygen, private-duty nurses where no intensive-care unit exists, routine physicals, vision and hearing examinations.
L–Pays $8 per day in non-Medicare participating skilled-nursing facility which participates with Massachusetts Blue Cross.
M–Certain private nursing services at home.
N–Emergency-ambulance service.
O–Catastrophic major-medical benefit, including prescription drugs, physical therapy, and outpatient psychiatric services.
P–Outpatient psychiatric services.
Q–Hospice benefits.
R–"Costwise participating doctor program."
S–Pays in skilled- and intermediate-care nursing facilities whether or not approved by Medicare.
T–One mammogram screening.
U–Pays benefits for in-home recovery services following stay in a hospital or skilled-nursing facility.
V–Certain therapist services.
W–Licensed independent clinical social workers.
X–Coverage for Blue Shield participating nurse midwives.
Y–Private-duty and visiting-nursing services.
Z–Rental of wheelchair and durable medical equipment, orthopedic braces, independent laboratory exams, oxygen, anesthetics, physical therapy, and ambulance service.
AA–Accidental-death benefit (not allowed in Fla.).
BB–Membership in Eye Care Plan of America.
CC–Vision-care benefits.

THE INSURANCE HARD SELL

In April 1988 Allen Quinn Bounds of Pearl, Miss., received a card in the mail from Senior Citizens Health Services advising him of "new changes in Medicare." The card arrived in an official-looking black and white envelope and noted that the total health-care bill for seniors in 1984 was $120-billion, more than half of which was not paid by Medicare. The card warned that "effective on January 1, there were even more expenses for the Senior Citizen to pay" and that it was "very important" for Bounds to know about them.

Bounds was instructed to complete the card with his name, address, telephone number, age, and Social Security number and send it to a post office box in Dallas. In return, he would receive "information" on how to protect himself against "costly Hospital, Doctor, and Nursing expenses."

Nowhere on the card was there any hint that the "information" would come from an insurance agent, nor that the purpose of the card was really the sale of insurance.

If Bounds returned the card, his name could be sold as a "lead" to an insurance agent prospecting for buyers of Medicare-supplement policies.

A year earlier, an identically worded card sent to Californians by The Mail Box, a Dallas firm, was declared illegal by California insurance regulators, who decreed that the cards could no longer be sent into the state because they were misleading and deceptive. Insurance regulators in Mississippi apparently are not bothered by such deceptions.

Neither are regulators in most other states. Similar cards are flooding the mailboxes of senior citizens across the country.

The growth of Medicare-supplement policies has spawned an industry of deceptive mailings whose purpose is to deliver your name, address, and phone number to insurance agents. This "lead-card" industry, based in Texas, has largely been ignored by state insurance regulators and U.S. postal authorities.

Tricks of the trade

The lead-card companies buy names from firms that compile mailing lists, then send out deceptive mailings to the names on the lists. If you fill in and return the card enclosed in the mailing, the card will be sold to insurance agents for as much as $19 apiece. The lead cards provide an entrée to the living rooms of the elderly, where agents may persuade their "prospects" to switch policies, take more coverage than they need, or buy insurance policies that will not live up to the agents' promises.

A CU reporter posed as an agent and asked seven lead-card companies to send her samples of cards she could buy, along with price lists. What she received should have been enough to raise the hackles of the meekest state regulator.

The companies go to any lengths to persuade consumers to return the cards, distorting the Medicare program and raising fears of huge unpaid medical bills.

Misrepresentation and deception begin with the names used on the cards to make retirees think that the sender is a government official. While most cards disclose in tiny type at the bottom that the companies are not affiliated with Medicare or any government agency, one can hardly miss the import of such names as: Retired Persons Information Center; National Health Information Center; National Processing Office; Regional Processing Center; National Health Referral Services; Consumer Referral Service Center, Medicare Division; Information Distribution Office; or Senior Citizens Health Services. To further the impression of a government connection, some companies direct recipients to return the cards to post-office boxes in Washington, D.C.

A few lead-card companies masquerade under names likely to be confused with well-known consumer and retiree organizations like the American Association of Retired Persons.

The imitators claim to provide services for retirees. But the services are largely limited to brochures. Some brochures advertise senior-citizen discounts, many of which seniors could obtain on their own. Others provide information on subjects ranging from flu prevention to finding the right lawyer. The National Federation of Retired Persons, for example, offers 16 brochures that are merely reprints of pamphlets published by the U.S. Department of Health and Human Services; they're available to anyone from the Federal government's Consumer Information Center in Pueblo, Colo.

The art of crafting a successful lead-card lies in disguising its connection to insurance. The card must kindle enough interest in Medicare to encourage a response, but without arousing suspicion that an insurance agent will call.

A sales representative for National Referral Systems advised our reporter to avoid sending "qualified" lead-cards—ones that mention the word "insurance" or identify a specific insurance company or policy. With these cards, she warned, "it's easy to get 'porched.' They won't let you in the door." National Referral's sales literature advertises that its promotions are successful because "a company name or agent name is not noted on the mail piece."

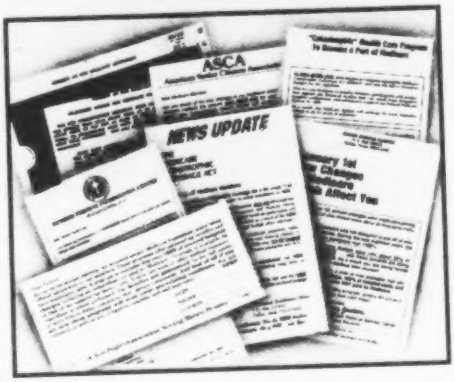
Some lead-cards do refer to a "plan" or "program," but avoid tying it to "insurance." A favorite trick is to link the plan to the words "100 percent" to imply that the sender will rush details of something that pays every penny of a person's medical bills. But lead-card companies send nothing to consumers, and the chances are slim indeed that every agent who comes calling will actually sell the rare plan that pays every bit of every claim.

Regulators take a walk

Failing to mention the word "insurance" next to the word "plan" is a violation of the advertising regulations for accident and health policies adopted by 48 state insurance departments. The regulations also direct that "advertisements shall be truthful and not misleading in fact

DECEPTIVE SALES TACTICS

A LEAD CARD SAMPLER



Companies mailing lead cards latch onto any change in Medicare to pique consumer interest. "Right now anything with catastrophic on it will pull," said a sales representative at National Referral Systems. "In effect the Catastrophic Act has been turned around to help us. We can market that very easily."

And market it they do, as the cards sent to our reporter show.

The message on the card from the "Tax Savings Information Services," a trade name used by The Mail Box, announced: "Important: New Catastrophic health bill effect . . . Congress and the President are now proposing new stopgaps in your Medicare coverage . . . Warning . . . It is very important that you find out about the changes under this new bill, because previous information will no longer be current."

What were the "stopgaps" Congress proposed? None. But the words conveyed a sense of urgency designed to make someone return the card.

A lead card from the "Retired Persons Information Center Washington, D.C." made this dire pronouncement: "During the past seventeen years, your share [of Medicare's costs] has increased over 800 percent and according to the government's latest report, 'Congress has approved an additional One Billion Dollar Cut in Medicare payments.' "

The fears raised by the card are unfounded. Over the years, beneficiaries' share of Medicare's costs has actually gone down. For Part B alone, their share has decreased from about 65 percent in 1975 to 47 percent in 1985. True, Medicare has cut payments to doctors and hospitals. But it has *not* touched those made to beneficiaries, as the lead card implies.

Nevertheless, the Retired Persons Information Center, a trade name used by U.S.A. Lead Systems, had "found a new program that can help solve this National problem." What was it? An insurance policy, of course, that paid "100 percent of the HOSPITAL and pays on DOCTOR'S charges both IN and OUT of the hospital."

Since Medicare pays 100 percent of the hospital charges, except for the deductible, and all Medicare-supplement policies pay some physicians' fees, we asked what program the Center had in mind. The manager of lead sales admitted that the Center had no program, and that the card was loosely worded so any insurance agent could use it.

National Referral Systems sent seven cards for our reporter to choose from. One, a "special bulletin" from National Referral's "Dispersement Office," says, "For the first time in history, Congress has adopted a new system of regulating Medicare and Catastrophic protection payments under the new Catastrophic Protection Act [sic]. Because of these regulations, many hospitals are transferring patients to lower-cost nursing homes or similar EXTENDED CARE FACILITIES."

The Catastrophic Act did not institute a new regulatory scheme as the card suggests. The DRG-payment system the card refers to was adopted four years earlier.

The Dispersement Office warned seniors "it is very important that you know about these regulations," and urged them to complete the card "immediately." It promised to "rush you complete information concerning the new changes in Medicare."

Despite its promise, the Dispersement Office rushes nothing to senior citizens. Information comes directly from the insurance agent who has bought the leads.

Another card from National Referral's "Senior Citizens Division" warned that "the Federal Medicare System pays only about 50 percent of your medical expenses . . . and those benefits are being significantly REDUCED."

Benefits reduced? Hardly. The Catastrophic Act significantly increased benefits, and for many seniors, Medicare pays much more than half their medical expenses.

American Response Marketing also sent several sample cards. One from the "American Senior Citizens Association Medicare Information Dept., Washington, D.C." asked: "Are you aware of the new changes in our Medicare system? These changes increase the amount YOU MUST PAY for your personal health care."

The card advised that the Association would furnish "information concerning the new changes and a supplemental plan which will help pay the expenses not paid by Medicare."

Does the American Senior Citizens Association actually furnish a plan? "No, we don't have a plan that I'm aware of," said a sales representative in Dallas. She did say that agents could give prospective policyholders a packet of material about the association. The sample packet sent to our reporter contained brochures advertising discounts on everything from bird feeders to Bibles, but not a single word about insurance.

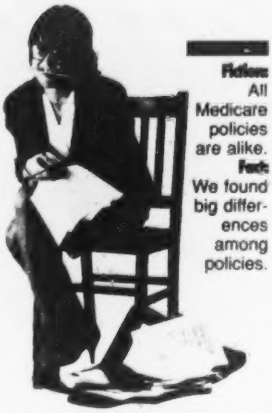
A card from the National Federation of Retired Persons advised that at its "recent annual meeting" it reviewed several Medicare-supplement plans and found some so exceptional that "if you act now, these programs will even cover pre-existing conditions"—obviously appealing to those with chronic health conditions.

We did find some plans with no waiting periods before coverage begins for existing health problems, but doubt these are the same policies National Federation of Retired Persons had in mind. None of the policies it submitted to Washington state regulators in response to a subpoena to substantiate lead-card claims were the ones we found without pre-existing conditions clauses.

In fact, the sketchy brochures National Federation did submit showed that four policies actually *limited* coverage for pre-existing conditions. We weren't sure about the fifth, since the brochure furnished too little information.

Fiction:
This policy pays 100 percent of your bill.
Fact:
It pays only 50 percent of excess charges up to 100 percent above Medicare's allowable charge.

Fiction:
All Medicare policies are alike.
Fact:
We found big differences among policies.



or in implication," and must not "create undue fear or anxiety in the minds of those to whom they are directed." Furthermore, most states have "little FTC" laws that allow their attorneys general to file lawsuits against companies engaging in misleading and deceptive practices.

But with the exception of insurance regulators in Washington, California, Oregon, Wisconsin, and Florida, and the attorney general of Illinois, state enforcement agencies have hardly questioned the activities of lead-card companies.

Last year, the attorney general of Illinois obtained a consent judgment against Senior Citizens Marketing Group under which the company agreed not to engage in certain deceptive practices. It obtained from National Referral Systems an assurance of voluntary compliance for similar practices.

But cards that trouble a regulator in Washington, California, or Illinois may cause no concern in New York or Mississippi. National Referral's sales representative told our reporter, based in New York, that the company could send anything it wanted to New York because regulators there "look the other way. They don't pay attention to what we mail."

Cards that fall afoul of regulators in some states soon pop up in others where regulators don't seem to mind. "We were hoping that by filing one or two cases, we'd send a message, but obviously we haven't," says Delores Martin, an assistant attorney general in Illinois.

Sometimes cards outlawed in one state are sent unchanged to consumers in others, like the one The Mail Box sent to Allen Quinn Bounds in Mississippi. But other times a company changes the name and slightly alters the message before sending a card to another state. Senior Citizens Marketing Group, for instance, sent our reporter in New York a card worded almost—but not exactly—the same as a card outlawed by the Illinois attorney general in early 1988.

Because it's easy for a company to change the name and the message on its cards, and because different companies use similar trade names, even tough regulators have trouble insuring compliance with their orders.

Our reporter found that a lead card from National Referral Systems using the trade name National Health Referral Services had been sent to consumers in the state of Washington several months after the insurance commissioner ordered Consumer Referral Service Center and its affiliates (including National Referral Systems) to stop sending misleading and deceptive cards.

The card we found purported to be taking a survey of senior citizens' attitudes toward the catastrophic health-care legislation then making its way through Congress. Was National Referral really taking a survey? "No," said a sales representative, "but it was a real neat card."

Regulators in Washington state also ordered all the affiliates of American Senior Citizens Associaton (including American Response Marketing) to stop sending deceptive cards into the state. A card sent to our reporter by American Response Marketing was identical to one that was mailed to Washington residents after regulators had issued their cease and desist order. This time the card used the name National Health Information Center.

Some of the lead-card companies didn't want to talk to us about their business. Morris Kuhn, of U.S.A. Lead Systems, said his company was not mailing lead cards for Medicare-supplement policies. "Get someone here and try to get them to get a card. We don't have anything to mail," Kuhn said. Two weeks earlier, our reporter had phoned U.S.A. Lead Systems and received a sample card and price list for Medicare-supplement policies.

Al Wilburn, president of National Referral Systems, said his company was not mailing any lead cards unless they had been approved by specific insurance companies and by state regulators. But our reporter obtained seven sample cards from National Referral, and none referred to a specific insurance company or product. National Referral's sales representative was only too willing to tell our reporter how to use the cards successfully.

A sorry tale in Texas

While lead-card companies appear to be unrelated to one another, their modus operandi is the same, probably because over the years, principals of one firm or another have left to start their own version of the business.

Except for U.S.A. Lead Systems, none of the lead-card companies seems to be backed by well-known insurance companies. U.S.A. Lead Systems uses a first-class mailing permit issued to AMEX Life Assurance Co., a subsidiary of American Express and a big seller of long-term-care insurance. (Agents use similar lead cards to find customers for long-term-care policies.)

Many of the companies began operations in the late 1970s or early 1980s, but until recently, Texas insurance regulators and the state attorney general have done little to stop their home-grown scam.

Eight years ago, the Texas Board of Insurance concluded it could do nothing to stop the lead-card companies since they did not actually sell insurance and thus were not under the jurisdiction of the board or any

Fiction: Medicare has cut the approved amount by 467 percent.

Fact: Medicare has not cut the approved amount for beneficiaries.

of its statutes and regulations. (Regulators in other states have taken action against companies precisely because they *were* acting as unlicensed agents soliciting insurance in violation of state laws.)

"While lead-card solicitations may be annoying, they are not where you have substantial misrepresentation," says Tony Schrader, a division director for the Texas Board of Insurance. "The misrepresentation is with the agent. They [the cards] may add a beginning foundation that is bad, but the real problems are in the actual sale."

Delivering the pitch

The history of Medigap policies is littered with cases of agent abuse—overselling, misrepresentation, deception, and outright fraud. Despite numerous Congressional hearings and laws prohibiting misrepresentation and the sale of duplicate coverage, these abuses are still alive and faring all too well.

Our reporter, posing as a family relative, listened to seven sales pitches given to old people in California and Texas and found them sprinkled with enough exaggerations, half-truths, misstatements, and violations of insurance laws to confound even the most knowledgeable buyer.

In California, the first agent she listened to is a defendant in a case brought by the district attorney in Santa Cruz. He's charged with engaging in unfair business practices, specifically selling excessive insurance coverage. But the charges apparently had made little impression. He tried hard to persuade his 84-year-old prospect to sign a check totaling $4673 to cover premiums for a Medicare-supplement policy, plus long-term-care and home-health-care policies.

Fiction: Medicare benefits are being significantly reduced.

Fact: The Catastrophic Coverage Act has significantly expanded benefits.

His pitch deftly moved from lower-priced policies to higher-priced ones, which, of course, would bring the highest commission. He trashed AARP's policy, and said United American's policy with its $924 annual price tag was "okay if that's all John [the prospective buyer] can afford." The agent had his heart set on selling the policy of Garden State Life Insurance Co. with an annual premium of $1291.

When the prospect said he could not afford a policy now, the agent stepped up the pressure: "Can you afford not to have it? I'm trying to convince you to get something. You're sitting here with nothing, and this premium is not out of line for a little over $100 a month." As it turned out, the man did own a Medicare-supplement policy; the agent didn't bother to ask about it.

When no amount of cajoling worked, he left, leaving no brochures, no literature, and no outline of coverage, as required by the California Insurance Department.

Another agent also began his pitch by knocking the competition. "Blue Cross and Blue Shield plans are not recommended," he advised. (That was one of the few true statements he made. The policy submitted by Blue Cross of California was dead last in our Ratings.)

He then told his prospective buyer, an 80-year-old woman, that she should take a private room when she went to the hospital so she wouldn't "be susceptible to all the stuff that's going around." It so happened that the Pioneer Life policy he was promoting paid for private rooms, a luxury hardly central to the value of a Medicare-supplement policy.

This policy, he said, "paid six times more," a figure pulled out of thin air. Later he said it paid "double what Medicare approves. This is the most liberal contract in the country." (Pioneer's policy, while a good one, is not the most liberal one we found.)

When asked for literature to back up his claims, he replied: "I could give you a thousand brochures, and they all say the same thing." When he finally produced one sketchy piece of printed information, it was not the outline of coverage required by California regulators.

The third agent wanted to know how much money his prospects had in the bank, a vital clue to how expensive a policy he could sell. He sold a variety of plans, explaining them in a very confusing way. Finally, he recommended that the 65-year-old woman and her husband buy a policy from Standard Life and Accident Co.

This policy, he said, "paid 100 percent of what was uncovered in the doctor area"—a true statement only if the doctor's excess charges did not exceed 50 percent of Medicare's allowable charges. That's all the outline of coverage said the policy would pay. (This policy was not the same one we rated.)

The top of the outline disclosed that the policy "does not usually cover custodial care," and another page said unequivocally that the policy did not pay for such coverage. But the agent insisted that it did, offering as proof a memo from the home office saying the coverage was provided by a rider.

When our reporter looked closely at the memo, she discovered the riders were for other policies, not the one this agent was selling.

Another California agent was peddling fear along with insurance. He said Medicare approved less than 50 percent of the bill, and since 1981, it had cut the approved amount by 467 percent.

To allay the fear that this and other falsehoods aroused in his 75-year-old prospect, the agent produced Garden State's policy, which he said "pays 100 percent of the bill—the only plan that pays 100 percent of the charges without a limit."

That statement was also false. The outline of coverage said the policy paid 100 percent of charges that were "usual" and "customary."

One of the agents in Texas took a different tack, claiming "a 100 percent policy is a thing of the past" because "they're too expensive." He showed a policy from United American. "It's a full 100 percent policy; it pays for everything, but I'm not going to tell you to buy it," he said. The agent then showed another United American policy, insisting it would pay all but $200 of a claim. A few minutes later, he added that if a doctor charged a lot, the amount not covered might be more. His prospect was confused.

Another Texas agent also favored United American. "There's nothing better on the market," he proclaimed. We found several policies better than United American's.

Our reporter did find one bright spot in her otherwise dismal shopping trip. One Texas agent called at the last minute to cancel his appointment. He begged off saying that he wanted to sell only the policy from Golden Rule, and that new brochures and sales material had not yet arrived. Golden Rule's plan was the best on the market, he said, adding it wouldn't be fair to present old brochures, since the benefits had changed.

He was right on both counts.

The failure of regulation

In the early days of Medicare, the 50 state insurance commissioners put few restraints on the sellers of Medigap policies. In the resulting free-for-all, *caveat emptor* was the watchword. There were no standards for policies and misleading sales pitches were more rule than exception.

But in 1980, after well-publicized hearings, Congress passed the so-called Baucus amendments (named for Sen. Max Baucus, a Democrat from Montana). The amendments ordered regulators to set minimum benefits for policies, or the Federal government would do it for them. Fearing Federal regulation, states quickly adopted standards that required policies to cover the 20 percent Medicare copayment and meet a target loss ratio of 60 percent. (The loss ratio is an indicator of whether policyholders are receiving good value for their money; in general, the higher the better.)

The Baucus amendments also attempted to crack down on agent abuse by making it a Federal crime to impersonate a Medicare official and to sell duplicate coverage. Only one case has been brought for the first offense, and that never came to trial. Despite the mountains of anecdotal evidence that selling duplicate coverage continues, the Health Care Financing Administration has received few complaints and has closed most of those without taking action.

To run afoul of the law, an agent must ***knowingly*** sell a policy that duplicates another. One way not to know is not to ask. So many agents don't bother asking if a prospect already has a policy. If a sales solicitation gets to the application stage, many companies require their agents to note whether the policy being sold will replace another. Such requirements on the part of insurance companies have been a weak control at best.

Furthermore, the law says a policy duplicates another only if it won't pay when the other does. Since there's no coordination of benefits with these policies, and each will pay, there's no duplication in the eyes of the law.

"A lot of state officials think things got cleaned up with Baucus," says an investigator with the U.S. General Accounting Office. Indeed, regulators in Maine told us that the Baucus amendments "cleaned up the systemic problems in this market," and only an "occasional problem" arises. New Jersey regulators said they had found no evidence of sales abuses.

If regulators think the Baucus amendments cleaned up the Medicare-supplement industry, they're living on another planet. Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the standards require.

Surveying the states

To see how well states were regulating Medicare-supplement policies, we sent a questionnaire to all 50 insurance commissioners. Thirty-seven responded. With few exceptions, we found, most states are regulating with a velvet glove.

In 1985, the General Accounting Office found that many states had no system for tracking complaints about Medicare-supplement policies. In 1989, our survey showed they still don't have them. Twenty-three regulators could not tell us how many complaints had been made to their departments in the last five years. These complaints, they said, were lumped together with others, making it impossible to know whether Medigap policies were even a problem. A few other regulators said they had just started keeping records. Some didn't even bother to answer the question.

Nor could some of the states tell us how many enforcement actions they've taken against agents in connection with the sale of these policies. Only nine listed any fines, license revocations, or suspensions for agents who had sold Medicare-supplement policies, and no doubt some of these were for failing to forward premiums to insurance companies rather than for deceiving the elderly. A few regulators did say they had taken enforcement actions, but didn't know how many, since their record-keeping system is still in the Dark Ages.

Some acknowledged they did not regularly review advertising and sales materials, although if a violation stared them in the face, they would pursue it. Only eight states reported any penalties against companies for misleading advertising.

Michigan regulators require prior approval of all advertising and sales material, but said the number and names of companies penalized for misleading and deceptive material were "not available." We always thought enforcement actions of public agencies were public—that is, if there are any.

Fifteen regulators did not routinely monitor policy loss ratios for both individual and group policies. Without such a program how can they know whether policies sold in their states meet the target loss ratios required by the Baucus amendments? To their credit, some states were on top of this problem. Regulators in Arizona, Colorado, Florida, Kansas, Missouri, Pennsylvania, South Dakota, Washington, and Wisconsin either provided us with lists of policies that didn't meet

the standards, or indicated they had taken action to bring policies into compliance.

Even though many state regulators appear to have a weak or nonexistent enforcement program, they believe their laws are adequate to deal with Medicare-supplement policies. Louisiana-regulators, for instance, told us they had no difficulties prosecuting agents. But how would they know? Louisiana regulators said the number of enforcement actions against agents was "undeterminable."

What's to be done?

The problems surrounding the sale of Medicare-supplement policies are systemic ones, calling for systemic solutions.

More doctors should accept Medicare's allowable charge as payment in full. States can mandate that they do, or the Federal government can beef up financial incentives to make it more attractive for doctors to become "participating" physicians.

If all doctors were participating, then policies providing excess coverage would be unnecessary; a simple and cheap plan of the type offered by Blue Cross and Blue Shield and the AARP would be enough.

Until the Federal government solves this larger problem, state regulators could take some immediate steps to ensure that buyers of Medigap policies are not victimized by unscrupulous sales people.

☐ The high commission paid to agents is the engine that drives the abuse. If first-year commissions were slashed, and companies were required to pay level commissions, for, say, the first four years, the incentive to misrepresent and replace policies would vanish.

☐ Policies should contain coordination-of-benefits clauses, or at the very least, the Baucus amendments should be rewritten to define duplicate coverage to mean coverage of the same expenses by two or more policies.

☐ Most regulators require agents to give policyholders an outline of coverage that summarizes the provisions of a particular policy. These outlines can be used effectively to compare policies if they are provided when buyers are actually shopping. The trouble is, regulators require agents to leave the outlines at the wrong time—when an application is taken and buyers have made up their minds and handed over a check to the agent. That's too late. Outlines must be given at the time of solicitation, whether or not an application is taken.

☐ Standardized policies would also help eliminate the confusion buyers now face. Many companies have several offerings with only slight differences among them. A few states require companies to offer only three types of policies, each with different levels of benefits.

Language in the policy and in accompanying sales brochures must be simplified to eliminate the impression that a policy pays a greater amount of the excess charges than it actually does.

☐ A few states, such as Washington, California, and New Jersey, operate insurance counseling programs for the elderly. These have saved money for senior citizens and helped them buy appropriate coverage. Other states should consider establishing such a service.

☐ The National Association of Insurance Commissioners (NAIC) should establish a standing committee to review advertising and approve its use in all states. But in the meantime, regulators should pay more attention to the enforcement actions taken by other states and reported to the NAIC's clearing house. The insurance commissioner in Mississippi should have known that lead cards sent into his state were illegal in California. This should have prompted him to take action, too, sparing Mississippi residents the blandishments of high-pressure agents. States have had 20 years to regulate this industry effectively. Most have missed their chance. They shouldn't be allowed many more. ■

Reprints of this report are available in bulk quantity. For information and prices, write CU/Reprints, P.O. Box CS 2010-A, Mount Vernon, N.Y. 10551.

HOW UNCLE SAM FAILS

THE CASE OF THE TARDY REPORT

It's tempting to say the Federal government should regulate Medigap policies, most of the states having done such a poor job. But if the seven years it took the Health Care Financing Administration (HCFA) to issue a report on how well the states were regulating these policies is a guide, then the Federal government can't be expected to do much better.

The report, a victim of political maneuvering, industry lobbying, and bureaucratic bungling, would have helped Congress determine whether state regulations were working to clean up the industry.

The 1980 law also directed HCFA to prepare a report on the effectiveness of state regulation by January 1982. That report was to cover not only Medigap policies but also related dread-disease insurance and hospital-indemnity policies. Congress was specifically interested in whether the policies were meeting their target loss ratios, a rough measure of a policy's value to the consumer, and the heart of the mandated standards.

From the start, the report ran into trouble. Fifteen months after the order from Congress, the agency finally contracted with an outside firm to do the research. But the collection of data ran into snag after snag, partly because some companies selling dread-disease policies (which provide coverage only for specific illnesses) refused to cooperate.

The first draft was completed by the end of 1984, but there were at least 12 more drafts, each of them subject to political pressure and numerous revisions. At one point, a reviewer required the deletion of material critical of Medicare-supplement policies because it had been supplied by a committee chaired by Rep. Claude Pepper, Capitol Hill's champion of the elderly. The reviewer wrote on the report: "Claude Pepper's Committee. This is insane. We are Republicans. Remember, we don't agree with Claude Pepper."

The HCFA officials who had opposed the report eventually left the agency, and some of the survey data made it into the hands of certain members of Congress, but that didn't mean the report was back on track. Congress was now considering catastrophic health-care legislation, and bureaucrats at the Office of Management and Budget, which reviews the agency reports, reasoned that they couldn't issue a report critical of the way private insurers handled supplemental policies if the Reagan Administration also wanted private insurers to provide coverage for catastrophic illness.

No one needed to worry. The report that finally surfaced in 1987 was watered down and brief. By that time, Congress had lost interest.

PREPARED STATEMENT OF JANET SHIKLES

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss the work we have done on Medigap insurance and recent developments related to Medigap. As you requested, we will be discussing 1990 Medigap premium increases, the percentage of premiums paid out as benefits (the loss ratios) in 1988, and recent changes in Federal and state regulatory requirements for Medigap policies.

MCCA AND ITS REPEAL

The Medicare Catastrophic Coverage Act (MCCA) which became law in July 1988, provided for the most significant expansion of Medicare benefits since the program's beginning. Beneficiary out-of-pocket costs for covered services were to be capped, and additional services would have been covered when the law was fully implemented.

In June and April 1989, we testified before committees of both houses of the Congress on the effects of MCCA on benefits provided by the Medicare program and Medigap insurance.[1] In both instances, we noted that MCCA expanded Medicare benefits and thus reduced the coverages required of Medigap policies. We pointed out that a number of major benefits provided under MCCA would become effective in 1990, and we expected that Medigap premiums for 1990 would be substantially lower than they would have been without MCCA.

In November 1989, the Congress passed legislation to repeal MCCA and to restore Medicare benefits to what they were before the Act became effective. The repeal legislation reversed the reduction in coverage required of Medigap policies, and we expected this would result in significantly higher Medigap premiums than if MCCA had remained in effect.

PREMIUMS FOR MEDIGAP INSURANCE AFTER REPEAL OF MCCA

During the debate surrounding the repeal of MCCA, concerns were raised in the Congress about the effect repeal would have on Medigap premiums and how the additional premium increases would affect low-income elderly persons. We recently contacted 29 commercial Medigap insurers to obtain (1) their estimate of their 1990 premiums and (2) their reasons for premium changes.[2]

Twenty companies responded to our request and are listed in appendix I to this statement. The policies sold by these 20 companies covered about 2.6 million policyholders, and they estimate their 1990 premiums will, on average, be 19.5 percent higher than premiums in 1989. The average increase is $11.44 per month. The increases range from 5.0 percent to 51.6 percent, and one company reported that it expected its 1990 premium to be the same as its 1989 premium. Appendix II to this statement shows the estimates from the twenty companies.

The companies attributed about half of the expected premium increases to general inflation within the medical sector of the economy, increased use of health services by senior citizens, and higher than expected claims experience in prior years. The companies attributed the other half of the increase to repeal of MCCA. The companies said that changes required by repeal of MCCA included: (1) additions to benefits, such as coverage of the part A deductible or reducing the policy deductible for part B coinsurance coverage from $200 to $75, and (2) administrative costs associated with repeal of the MCCA, such as modifications to policies and notices to policyholders.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight organizations responded, representing two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent. The Association said that a 9 percent increase was projected prior to repeal of the MCCA. The Association said that plan rate increases reflect numerous factors, including growth in costs and utilization, benefit changes, and adjustments for prior rate inadequacies.

---

[1] See "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits," Statement of Mr. Michael Zimmerman before the Senate Committee on Finance (GAO/T-HRD-89-22, June 1, 1989) and "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums," Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-89-13, Apr. 6, 1989).

[2] See "MEDIGAP INSURANCE: Expected 1990 Premiums after Repeal of the Medicare Catastrophic Coverage Act," Statement of Ms. Janet Shikles before the Senate Special Committee on Aging (GAO/T-HRD-90-9, Jan. 8, 1990).

MEDIGAP LOSS RATIOS FOR 1988

In addition to concerns about increasing premiums for Medigap insurance, another area of congressional concern has been the percentage of Medigap premiums returned to policyholders in the form of benefits, or the policies' loss ratios. A loss ratio is computed by dividing the total incurred claims[3] for a period of time by earned premiums for the same period. The result of this computation is usually expressed as a percentage.

The Baucus amendment, which amended the Medicare law to establish Federal Medigap standards, set Federal targets for loss ratios for Medigap policies. The Baucus amendment required as a condition of approval that Medigap policies be expected to have loss ratios of at least 75 percent in the case of group policies and at least 60 percent in the case of individual policies. MCCA revised the Baucus amendment to require states to collect data on actual Medigap loss ratios.

In an earlier report[4] and other congressional hearings,[5] we reported on the loss ratios of Medigap policies. Generally, we have reported that pre-1988 loss ratios of most commercial policies were below the minimum standards. In contrast, the pre-1988 loss ratios of Blue Cross and Blue Shield plans were generally above the standards. For example, in our 1986 report, we reported that the 1984 average loss ratio for individual policies sold by 92 commercial firms was 60 percent; for policies sold by 13 Blue Cross and Blue Shield plans, the average was 81 percent. Loss ratio data for 92 commercial policies showed the average 1987 loss ratio was 74 percent; however, that average was heavily influenced by the relatively large block of business represented by the Prudential Insurance Company, whose loss ratio was 83 percent. Excluding Prudential, the other commercial policies had an average loss ratio of 59 percent. For 75 Blue Cross and Blue Shield plans, the 1987 average loss ratio on individual plans was 93 percent. Because of changes in loss ratio reporting requirements discussed below, these pre-1988 loss ratios cannot be directly compared with more current loss ratio data.

State insurance regulators caution on the interpretation and use of loss ratio data because a number of factors may affect the computations. For example, early policy experience may result in a relatively low loss ratio because policies do not cover costs related to pre-existing conditions during the policy's waiting period. Also, new policyholders may be relatively healthy and file few claims, so a policy with substantial amounts of new business may experience a relatively low loss ratio. Thus, loss ratios should be viewed over the time that represents "mature" experience. For reporting prior to 1988, the National Association of Insurance Commissioners' (NAIC) reporting form included the reporting year's experience for all policies in force and a cumulative report of the 3 most current years' experience. Beginning with reports covering 1988 and later, the NAIC provides a two-tiered set of criteria for determining if loss ratios comply with loss ratio standards:[6]

—*For policies that have been in force 3 years or more,* the most recent year's loss ratio must equal or exceed the 60 or 75 percent standard (whichever is applicable).

—*For policies that have been in force less than 3 years,* the policies must have a third-year expected loss ratio equal to or greater than the 60 or 75 percent standard.

In connection with work we have been doing for two Committees of the House of Representatives, we have obtained 1988 loss ratio data (the latest available) for Medigap insurance from NAIC[7] and the Blue Cross and Blue Shield Association. The data are reported in aggregate for all policies sold by a company. These aggregate data measure a company's overall performance because they average experience across all policies. This means that a company whose aggregate loss ratio is below the standards has one or more policies which fail to meet the minimum standards but may have other policies that meet or exceed the standards. Conversely, a company can have an aggregate loss ratio above the standards but offer some policies that fall below them.

---

[3] Incurred claims include actual payments for claims plus reserves for claims incurred but not yet received or processed by the insurer.

[4] *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies* (GAO/HRD-87-8, Oct. 17, 1986).

[5] See statements cited in footnote 2.

[6] In addition, the NAIC has revised the formula for determining the incurred claims portion of the loss ratio. Prior to 1988, incurred claims included actual payments for claims plus reserves for claims incurred but not yet reported to or processed by the company plus a life-time reserve for future claims. For loss ratios covering 1988 and later years, incurred claims no longer include the life-time reserves in the computation.

[7] The NAIC labeled its data "preliminary results only," and these data are subject to change.

The aggregate loss ratios by companies for policies in force more than 3 years that had more than $250,000 in earned premiums are summarized in appendix III. Similar data for policies that have been in force for 3 years or less are in appendix IV.

As in our earlier report and testimonies, many company loss ratios are still not meeting the minimum standards. In 1988, the loss ratios for companies with policies in force more than 3 years were based on total earned premiums of approximately $3.7 billion. For policies sold to individuals:

—By commercial insurers, 34 percent of the company loss ratios were below the 60 percent minimum standard. The average loss ratios for companies exceeding the standard was 68.5 percent while the average for companies below the standard was 50 percent.

—Among the Blue Cross and Blue Shield plans, 98 percent met or exceeded the target loss ratio percentage. The average loss ratio for these plans was 93.4 percent; the loss ratio of the single plan that fell below the standard was 53.9 percent.

For group coverage:

—About 66 percent of the commercial company loss ratios were below the 75 percent minimum standard. The average loss ratio for companies that were at or above the target was 101.5 percent, and the average for those below the target was 62.6 percent.

—Among the Blue Cross and Blue Shield plans, 24 percent had loss ratios that fell below the minimum target. The average loss for plans that met or exceeded the target was 94.1 percent, and the average for those below the target was 71.5 percent.

Earned premiums for policies in force 3 years or less totaled approximately $3.5 billion for 1988. For policies sold to individuals:

—By commercial insurers, 60 percent of the company loss ratios were below the 60 percent minimum standard.

—Among the Blue Cross and Blue Shield plans, all met or exceeded the standard.

For group coverage, about 71 percent of the commercial companies and 16 percent of the Blue Cross and Blue Shield plans did not meet the 75 percent target. Additional details are in appendix IV.

Under the Baucus amendment, states are responsible for monitoring whether Medigap policies meet the loss ratio standards and for taking action when they do not. In the past, states did little to assure that the loss ratio targets were actually met. This was because the loss ratio standards were expressed as targets and the manner in which loss ratio data were reported by insurers did not facilitate monitoring. Under the revised Federal and NAIC loss ratio standards, loss ratios *must* meet the standards after 3 years and the form in which loss ratios are reported will make such determinations easier than in the past. When states adopt the new standards, they should be better able to enforce the standards than was the case previously.

REGULATORY REQUIREMENTS FOR MEDIGAP POLICIES AFTER REPEAL OF MCCA

Over the years, another congressional concern related to Medigap has been marketing abuses and consumer protections against those abuses. NAIC's most recent revision to its model regulations, adopted in early December 1989, included several new consumer protection provisions along with changes to the minimum standards which were needed because of MCCA's repeal. These new standards will be the criteria for approval of state regulatory programs under the Baucus amendment and are now before the states for their consideration and adoption. The new NAIC standards continue efforts, which began with the passage of the Baucus amendment, to eliminate abuses in the sale and marketing of Medigap insurance. We believe that if adopted and enforced by the states, they will help prevent abuses in the sale of Medigap policies.

One problem in the sale of Medigap insurance that has been identified over the years is that some Medicare beneficiaries purchase multiple policies that duplicate coverage. Revised consumer protection provisions in the NAIC model should help alleviate this problem. Application forms will include questions asking whether the applicant has another Medigap policy in force and, if so, is the policy being applied for intended to replace any medical or health insurance already in force. Agents must also list on the application any health insurance policies they have sold to the applicant. The sale of more than one Medigap policy to an individual is prohibited, unless the combined policies' coverages do not exceed 100% of the individual's actual medical expenses. In addition, if the sale involves replacement of a Medigap policy, an insurer or its agent must provide the applicant with a notice before the replacement policy goes into effect that the coverage applied for replaces health insurance in force. This notice will give purchasers an additional opportunity to review their coverage and to cancel the new policy without penalty if they decide not to replace a policy already in force.

Another problem with Medigap marketing has been frequent replacement of policies which results in new waiting periods for pre-existing conditions. New provisions should decrease the incentives to sell new policies by placing restrictions on the way commissions are paid and prohibiting waiting periods when replacement policies are sold. The compensation provision limits the first-year commission and other compensation [8] that may be paid to an agent selling a Medigap policy and also requires companies to spread the total compensation for selling a policy over a reasonable number of years. These requirements will prevent companies from loading agent compensation into the first years a policy is in effect, thus decreasing the incentive to sell replacement policies. Also, when issuing a replacement Medigap policy insurers must waive waiting periods applicable to pre-existing conditions or other similar restrictions to the extent such time was spent under the original policy.

In addition to the consumer protection provisions, the new NAIC model regulation modified some minimum benefit standards for Medigap policies from those required before MCCA was enacted. For example:

—*For services covered under Part A of Medicare.* Current NAIC standards require Medigap policies to cover either all or none of the part A deductible ($592 per benefit period in 1990) The NAIC standard in effect before MCCA did not contain a minimum requirement for coverage of the part A deductible, and thus a policy could have covered just a portion of that deductible.

—*For services covered under part B of Medicare.* NAIC's current standards require Medigap policies to cover all policyholders' coinsurance for services covered by part B of Medicare, after the policyholder has paid the part B deductible of $75 per year. This coinsurance is 20 percent of the Medicare-approved charge for services. Prior to the MCCA, the NAIC standards required Medigap policies to pay part B coinsurance after the policyholder paid $200 (the $75 annual part B deductible plus $125 in part B coinsurance) and Medigap policies could limit coverage to $5,000 in benefits in any calendar year.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you have.

Enclosure.

APPENDIX I.—INSURANCE COMPANIES THAT RESPONDED TO OUR REQUEST FOR DATA

Prudential Insurance Company of America
United American Insurance
Bankers Life
Mutual of Omaha
Union Fidelity Life Insurance Company
National Home Life Assurance Company
Union Bankers Insurance Company
Standard Life and Accident Insurance Company
The Principal Mutual Life Insurance Company
Pioneer Life Insurance Company of Illinois
Pyramid Life Insurance Company
Associated Doctors Health and Life Insurance Company
Colonial Penn Franklin
State Farm Mutual Auto Insurance Company
Continental Casualty Company
American Integrity Insurance Company
New York Life Insurance Company
Provident Companies
American Republic
Atlantic American Life Insurance Company

---

[8] Compensation includes bonuses, gifts, prizes, awards, finders fees, and other similar forms of remuneration.

APPENDIX II.—EXPECTED INCREASES IN 1990 MONTHLY MEDIGAP INSURANCE PREMIUMS AFTER REPEAL OF THE MEDICARE CATASTROPHIC COVERAGE ACT 1990

Company	1989 monthly premium	1990 expected monthly premium	Increase (percentage)
Company AA	$50.00	$50.00	0.0
Company AB	83.09	87.26	5.0
Company AC	59.93	65.32	9.0
Company AD	73.96	81.29	9.9
Company AE	73.46	80.79	10.0
Company AF	61.65	70.15	13.8
Company AG	68.00	78.00	14.7
Company AH	81.00	94.00	16.0
Company AI	39.25	45.95	17.1
Company AJ	58.75	70.39	19.8
Company AK	68.00	81.52	19.9
Company AL	33.90	41.00	20.9
Company AM	57.65	70.33	22.0
Company AN	38.00	46.36	22.0
Company AO	43.29	53.68	24.0
Company AP	90.00	115.00	27.8
Company AQ	50.82	67.59	33.0
Company AR	43.84	59.67	36.1
Company AS	62.82	90.93	44.7
Company AT	32.95	49.95	51.6
Average	$58.52	$69.96	19.5

APPENDIX III.—DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS FOR POLICIES THAT HAVE BEEN IN FORCE FOR MORE THAN 3 YEARS

Individual	Commercial			Blue Cross/Blue Shield		
	Above 60% target	Below 60% target	Total	Above 60% target	Below 60% target	Total
Companies	87	44	131	50	1	51
Earned premiums (millions)	$690	$101	$791	$1,887	$.53	$1,888
Avg. Loss Ratio	68.5	50.0	66.1	93.4	53.9	93.4

Group	Commercial			Blue Cross/Blue Shield		
	Above 75% target	Below 75% target	Total	Above 75% target	Below 75% target	Total
Companies	10	19	29	26	8	34
Earned premiums (millions)	$600	$49	$649	$361	$48	$409
Avg. loss ratio	101.5	62.6	98.5	94.1	71.5	91.4

APPENDIX IV.—DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS

Individual	Commercial			Blue Cross/Blue Shield		
	Above 60% target	Below 60% target	Total	Above 60% target	Below 60% target	Total
Companies	55	83	138	36	0	36
Earned premiums (millions)	$650	$616	$1,266	$1,215		$1,215

APPENDIX IV.—DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS—Continued

Individual	Commercial			Blue Cross/Blue Shield		
	Above 60% target	Below 60% target	Total	Above 60% target	Below 60% target	Total
Avg. Loss Ratio	66.7	51.4	59.3	87.5	....	87.5

Group	Commercial			Blue Cross/Blue Shield		
	Above 75% target	Below 75% target	Total	Above 75% target	Below 75% target	Total
Companies	6	15	21	16	3	19
Earned premiums (millions)	$616	$48	$664	$364	$13	$377
Avg. loss ratio	99.9	55.8	96.7	92.6	67.3	91.7

GAO Responses to Questions of Senator Riegle

Question 1. In examining a cross section of policies, how do the benefits compare before and after the repeal of the Medicare Catastrophic Act?

Answer. The General Accounting Office has not had an opportunity to examine policies issued since the repeal of the Medicare Catastrophic Coverage Act; however, that act restored many Medicare benefits to what they were before the Medicare Catastrophic Coverage Act (MCCA) was passed. Medigap insurance policies are required to cover Medicare part A coinsurance, which would be necessary beginning with the 61st day of a hospital stay. Medigap policies must also cover a beneficiary's part B coinsurance, which is 20 percent of the approved charges for physician and other supplier services after the deductible has been paid. Policies may also cover the part A deductible ($592 for each spell of illness in 1990) and/or the part B deductible ($75 annually).

Changes in the model regulation for Medigap insurance since repeal of MCCA require policies to:

—Cover either all or none of the part A deductible. Prior to the change, a policy could have covered just a portion of that deductible.

—Cover all part B coinsurance after the Medicare deductible. Prior to the change, Medigap policies could have their own deductible up to $200 per year and could limit benefits to $5,000 per year.

Question 2. Would you compare the individualized cost for coverage before and after the repeal of the Medicare Catastrophic Coverage Act?

Answer. In December 1989, we surveyed 29 large commercial Medigap insurers and asked what they estimated their premiums would be after repeal of the MCCA. Twenty of these insurers responded. These companies had about 2.6 million policyholders. The average monthly premium for the 20 companies was $58.52 in 1989, and the average monthly premium for 1990 was expected to be $69.96, an increase of $11.44 or 19.5 percent. One company said it expected its 1990 premium to be the same as its 1989 premium.

The companies attributed about half of the expected premium increases to general inflation within the medical sector of the economy, increased use of health services by the elderly, and higher than expected claims experience in prior years. The companies attributed the other half of the increase to repeal of MCCA. The companies said that changes required by repeal of MCCA included: (1) additions to benefits, such as coverage of the part A deductible or reducing the policy deductible for part B coinsurance coverage from $200 to $75, and (2) administrative costs associated with repeal of the MCCA, such as modifications to policies and notices to policyholders.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight organizations responded, representing two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent. Had MCCA remained in force, the Association projected that premiums would rise by about 9 percent. The Association attributed plan rate increases to numerous factors, including growth in costs and utilization, benefit changes, and adjustments for prior rate inadequacies.

Question 3. Would you briefly discuss variations in State regulated consumer protection programs regarding Medigap policies?

Answer. In connection with on-going work on Medigap insurance, we recently visited 12 states to obtain information about their insurance regulatory program. All of these states had some assistance about Medigap insurance available for the elderly. The states provide informational literature and public service announcements, and generally the states will provide speakers for educational programs.

In addition to the above, 4 of the 12 states also had systems of volunteer counselors who advise seniors about insurance. These counselors help consumers compare insurance options, understand policy conditions and limitations, and assess the need for Medigap insurance.

Eight of the 12 states we visited published Medigap shoppers' guides. These guides provide information to the elderly to help them identify policies suitable to their needs, and many of them explain Medigap policies and contain charts comparing premiums and benefits for individual Medigap policies available in the state.

PREPARED STATEMENT OF ALAN P. SPIELMAN

Mr. Chairman, I am Alan P. Spielman, Executive Director, Government Programs Legislation, of the Blue Cross and Blue Shield Association. I appreciate the opportunity to testify before this subcommittee on the subject of Medicare supplemental insurance. Blue Cross and Blue Shield Plans underwrite benefits to supplement Medicare coverage for about eight and one-half million beneficiaries, approximately 42 percent of all beneficiaries who purchase such coverage. About two-thirds of these beneficiaries have individual Blue Cross and Blue Shield coverage; the others are covered under group policies.

Our testimony today will focus on three issues:

1. What is the effect of repeal of the Medicare Catastrophic Coverage Act (MCCA) on private Medicare supplemental policies, with respect both to benefits and adjustments to premiums?
2. How has the regulation of the Medigap market changed as a result of recent action by the Federal Government and the National Association of Insurance Commissioners (NAIC)?
3. Is there a need for additional Federal regulation of the Medigap market?

EFFECT OF REPEAL ON MEDICARE SUPPLEMENTAL INSURANCE

When the Medicare Catastrophic Coverage Act was repealed this past November, the Medicare program was returned to its former design, and the very gaps in benefits that the catastrophic legislation sought to close were created anew.

Under MCCA, the government assumed the full liability for Medicare hospital costs exceeding one deductible per year. The government also covered up to 150 days of skilled nursing facility care, subject to beneficiary coinsurance during the first eight days. In 1990, Medicare was scheduled to assume the liability for all Part B cost-sharing for physician and other medical services over $1,370.

The Congressional Budget Office estimated that the cost of all these new benefits would have been $7 billion in 1990. To finance these benefits, the Congress found it necessary to increase the Part B premium and establish a new Medicare supplemental premium.

Since private insurance has traditionally filled in most or all of the gaps in Medicare coverage for acute care expenses thus, the name "Medigap"—it is expected that private insurers will respond to the repeal of catastrophic by incorporating into their Medigap products most of the benefits lost under Medicare. The liability for catastrophic coverage for the elderly is thus being transferred from the Federal government back to the private sector. Now that the private sector is responsible for financing these benefits, most insurers will, as the government did, find it necessary to charge higher premiums.

But repeal of MCCA is not the only factor affecting Medigap premium levels. Overall, Medigap premiums are affected by the same cost and utilization trends that have been driving up Medicare spending. Between 1984 and 1989, Part B spending nearly doubled. Over the same period, the Medicare hospital deductible increased by 57 percent. A simplified illustration of the contributions of MCCA repeal and health care cost and utilization trends to Medigap cost increases is shown in Attachment A.

Another factor affecting rate increases is the adequacy of prior rates. Blue Cross and Blue Shield Medigap products are generally subject to stringent rate review. Regulators often have been reluctant to grant the Medigap rate increases necessary to keep pace with annual increases in the Medicare deductible and the utilization of services by beneficiaries. Indeed, a GAO study of Medigap loss ratios found a 1987 average loss ratio of 104 percent among the 6 Blue Cross and Blue Shield Plans it surveyed. This means that these Plans were paying out more in Medigap benefits than they collected in premiums. In these situations, the losses must be subsidized by other lines of business, which can increase the costs of health insurance to other groups and individuals.

With this overview in mind, I would now like to address the effects of repeal specifically on Blue Cross and Blue Shield Medigap policies. Blue Cross and Blue Shield Plan Medigap policies traditionally have provided our subscribers with substantial value and a broad range of benefits, generally significantly exceeding the minimum requirements of Federal and state law. That tradition was maintained when the Medicare catastrophic coverage legislation was in effect and will continue now that the legislation has been repealed.

In 1987 and 1988, the average Blue Cross and Blue Shield Plan non-group Medicare supplemental policy paid out more than 90 cents in benefits for each premium dollar received. Such returns substantially exceed the 60 percent loss ratio required of individual Medigap policies under the NAIC minimum standards.

In 1989, Blue Cross and Blue Shield Plan Medigap rate increases were quite moderate overall—about an 8 percent increase and a significant number of Plans were able to reduce rates or hold them constant because of the savings due to the MCCA.

Last fall, when Congressional and public interest in the impact of repeal on 1990 Medigap premiums sharpened, we developed both national estimates and survey data to respond to the need for information. First, we developed estimates of the range of potential increases in Medigap costs attributable to repeal of the catastrophic benefit. Based on national average data, we estimated that the monthly benefit and administrative costs associated with filling in the new gaps in Medicare coverage would be from $3 to $8 per person for catastrophic hospitalization, and from $2 to $8 for cost-sharing for skilled nursing care. We estimated that the repeal of the 1990 cap on Part B cost-sharing would cause a loss of savings to private insurers estimated at $3 to $8, a savings that would have been reflected in lower premium increases in 1990 had the law remained in effect. In total, then, the increase in projected Medigap costs resulting from the repeal of Medicare catastrophic coverage was estimated to be from $8 to $24 monthly in 1990.

We followed up these national estimates with a survey of Plans in November. Responses from 38 Blue Cross and Blue Shield Plans regarding their most commonly sold non-group Medigap products indicated that the median expected increase in 1990 premiums would be about 29 percent assuming the repeal of Medicare catastrophic benefits. If the law had remained in effect as enacted, the median premium increase would have been about 9 percent. These data are illustrated in Attachment B.

Since the December 7 adoption by the NAIC of revised Medigap regulations, several states have approved 1990 Medigap rates for Blue Cross and Blue Shield Plans. So far the magnitude of these approved rate increases is generally consistent with our earlier estimates.

CHANGES IN MEDIGAP REGULATIONS

Medigap insurance is governed by standards developed by the NAIC and adopted by states. These standards, which establish minimum benefit and loss ratio requirements, are also incorporated in Federal law. The standards are known as Baucus standards, after Senator Max Baucus (D-MT), the sponsor of the 1980 legislation establishing the voluntary Federal certification program. Under the law, the Federal voluntary certification program does not apply in states that adopt the NAIC standards or more rigorous ones.

When the MCCA passed in 1988, the Congress recognized that the standards for Medigap would have to be revised both to assure that the minimum benefit requirements did not duplicate the new Medicare benefits and to establish procedures for making any necessary adjustments in Medigap premiums. Appropriately, the Congress looked to state regulators to make the needed modifications, and the NAIC acted promptly in 1988 to develop transition rules and revised model standards for Medigap. The states had one year in which to adopt these standards and most states adopted the revised model standards by the statutory deadline.

When the Medicare catastrophic benefit was subsequently repealed, modification of Medigap products was again necessary. Once more, the Congress directed the NAIC to develop transition rules and revised model standards, which would be incorporated by reference into Federal law. The NAIC responded promptly. In an environment on the verge of chaos, the NAIC facilitated a smooth transition and should be commended for its swift and responsible action.

Under the minimum standards adopted by the NAIC on December 7, Medigap policies must cover: all or none of the Medicare hospital deductible ($592 in 1990); all Medicare coinsurance for days 61 through 90 of a hospitalization ($148 per day); all Medicare coinsurance for hospitalization during a person's 60 lifetime reserve days ($296 per day); 90 percent of hospital costs after exhaustion of the Medicare benefit, up to 365 additional days of hospital care; all Medicare Part B coinsurance for physician and other medical services after the $75 Part B deductible; and the costs of the first three pints of blood under both Part A and Part B of Medicare.

Also, the NAIC transition rules require that private insurers promptly notify their policyholders of the changes in Medicare and the corresponding changes in their Medigap policies and premiums. Consistent with the MCCA repeal legislation, Medigap insurers must also offer to reinstate coverage for policyholders who dropped their coverage in 1989 on substantially the same terms it was offered in 1988 without imposing any waiting periods for treatment of pre-existing conditions. All of these notices were required to be sent by the end of January.

The NAIC transition rules provide—both for 1989 when the industry was adjusting to the enactment of MCCA, and for 1990 when it must adjust to repeal—that premium changes must be reasonable and justified by the circumstances. Specifically, the NAIC rules provide that Medigap premium adjustments that are due to changes in Medicare benefits result in a loss ratio at least as high as that originally anticipated for the policy. The loss ratio measures how much of the premium goes to pay benefits under the policy—the higher the loss ratio, the greater the portion of the consumer's premium dollar returned as benefits. The intent of this NAIC rule is to prevent insurers from receiving "windfalls" solely as a result of legislative changes in Medicare benefits.

In addition to addressing issues concerning Medigap benefits and rates, the NAIC in December approved new standards to protect consumers in the Medigap market. The NAIC model consumer protections include provisions to:

- regulate agent commissions on replacement policies,
- require insurers and agents to ask questions to identify duplicative coverage,
- prohibit the sale of a Medigap policy to a consumer who already has such a policy and intends to keep it, and
- require insurers to waive preexisting condition provisions on any new Medigap policy that replaces another similar Medigap policy.

These provisions are contained in the NAIC minimum standards and as such have been incorporated by reference into the Medicare law.

ROLE OF THE FEDERAL GOVERNMENT

As a result of the Medigap provisions adopted by the Congress in the Medicare catastrophic repeal legislation and action by the NAIC, states, and private insurers, beneficiaries can be assured that their Medigap policies will provide protection against the costs of extended hospitalization and Part B coinsurance liability. Provisions of Federal and state law also help to protect consumers against unscrupulous sales practices and, as indicated previously, the NAIC recently adopted a comprehensive set of additional model provisions in this area.

In our view, most states did a good job of enforcing the original 1980 standards. In 1988, the Congress and the NAIC determined those standards needed strengthening, particularly in the area of compliance with minimum loss ratios. The mandatory reporting of loss ratio data by insurers and the analysis of those reports by insurance departments and the NAIC is on schedule. The Blue Cross and Blue Shield system is working closely with regulators and NAIC staff to ensure the accuracy of that data.

We believe that the Congress should continue to rely on the standards developed by the NAIC to ensure that consumers receive reasonable value and benefits in their Medigap coverage. We recognize, however, that some states are in a better position than others to devote resources to the rigorous enforcement of the wide range of Medigap regulations that have been developed. We are encouraged that in 1989 a number of departments received strong state gubernatorial and legislative financial support for this and other regulatory priorities. We believe that the Federal Government could play an important role in 1990 and beyond by encouraging the establish-ment and operation of effective state regulatory programs and supporting consumer education efforts, such as beneficiary counseling programs.

Should the subcommittee decide to proceed with changes to the Federal law provisions affecting Medigap, we recommend that you consider strengthening the Federal process for reviewing state regulatory programs. Specifically, states could be required to demonstrate that they have mechanisms in place for the review of Medigap loss ratios and that they take appropriate actions against policies that persistently fail to deliver reasonable value to consumers. Under this approach, the Secretary of Health and Human Services or the Supplemental Health Insurance Panel could be authorized to withdraw approval of the state's regulatory program if the program's effectiveness could not be verified. We believe that this proposal would strengthen Federal and state efforts to protect seniors who purchase Medigap without supplanting state regulatory authorities.

We do not recommend that you amend the Federal law penalties dealing with Medigap marketing abuses. We believe that the states should be given the opportunity to adopt the new NAIC consumer protection amendments and that the administrative feasibility of these amendments be tested through actual application before changes in Federal law are contemplated.

Finally, we have serious concerns with proposals to change the role of the Federal Government in this market to one of designing standardized benefit packages that insurers must offer to the elderly. Consumers have been well-served by worthwhile benefit innovations such as health promotion plans, dental coverage and eye care, and we believe that rigid control of the content of insurance policies would stifle, rather than enhance, market responses to changing consumer needs. Based on our experience in this market, beneficiaries will question why insurers have been required to drop benefits that beneficiaries considered valuable. In addition, standardized benefits could leave consumers with the mistaken impression that all Medigap insurance is alike, without revealing important differences among insurers in service, reliability and accessibility. Moreover, standardization would impede the development of innovations that may contain Medigap costs, such as the use of preferred provider networks.

Consumer education, not federally-prescribed benefit packages, is the best way to minimize beneficiary confusion in this market, and we would be pleased to work with the subcommittee on ways to accomplish this. One approach, which we proposed last year, would be to require insurers to show consumers how the Medigap policy offered for sale compares to the minimum standards.

CONCLUSION

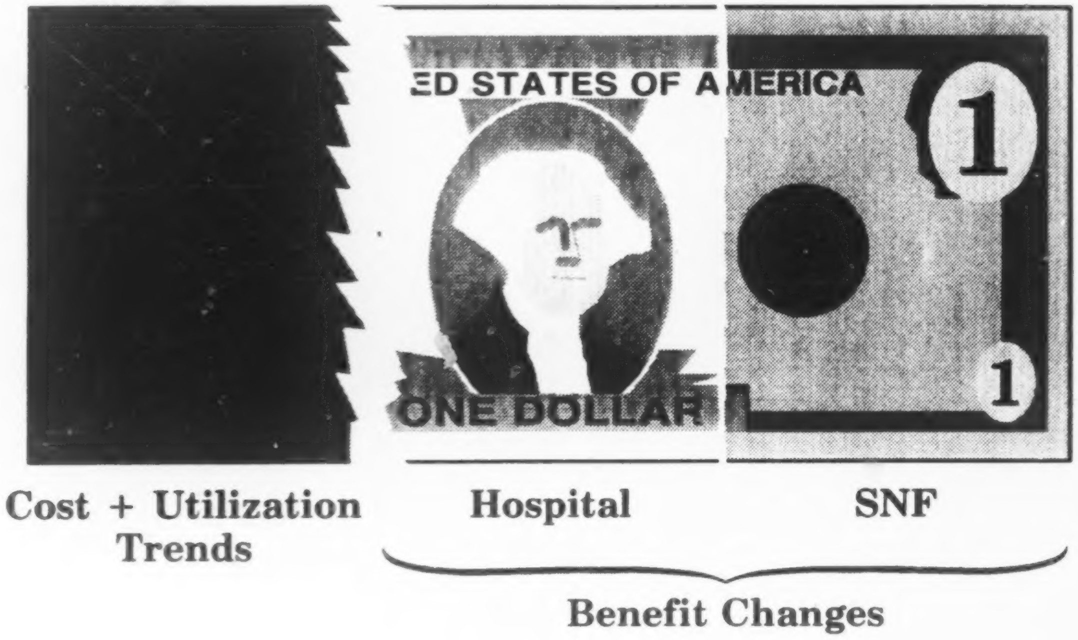
Most senior citizens who purchase private Medigap insurance to supplement their Medicare benefits will face increases in their premiums in 1990 due to the repeal of MCCA, rising health care costs and, in some cases, other factors. Their policies are being modified to assure that they will be protected against catastrophic acute care expenses. We in the Blue Cross and Blue Shield organization are committed to providing our subscribers with the benefits that meet their needs, the service they deserve, and exceptional value for their premium dollar.

We do not believe that additional Federal regulation of the Medigap market is necessary. We urge the Congress to continue its support of sound regulation of the Medigap market by states and to consider strengthening the criteria for Federal approval of state regulatory programs.

We would also urge you to continue to examine ways of containing rapidly rising Medicare costs, particularly in Part B. We supported the initiatives taken by this subcommittee to reform physician payment under Medicare, and are hopeful that these reforms will help slow the growth in Part B spending over time. Reducing Part B spending growth will help restrain increases in the Medicare Part B premium and in private Medigap insurance premiums. In the short term, if the Congress wishes to provide some financial relief to beneficiaries facing Medigap premium increases, you may wish to consider reinstating some version of the health insurance premium tax deduction that was available to individuals prior to 1983.

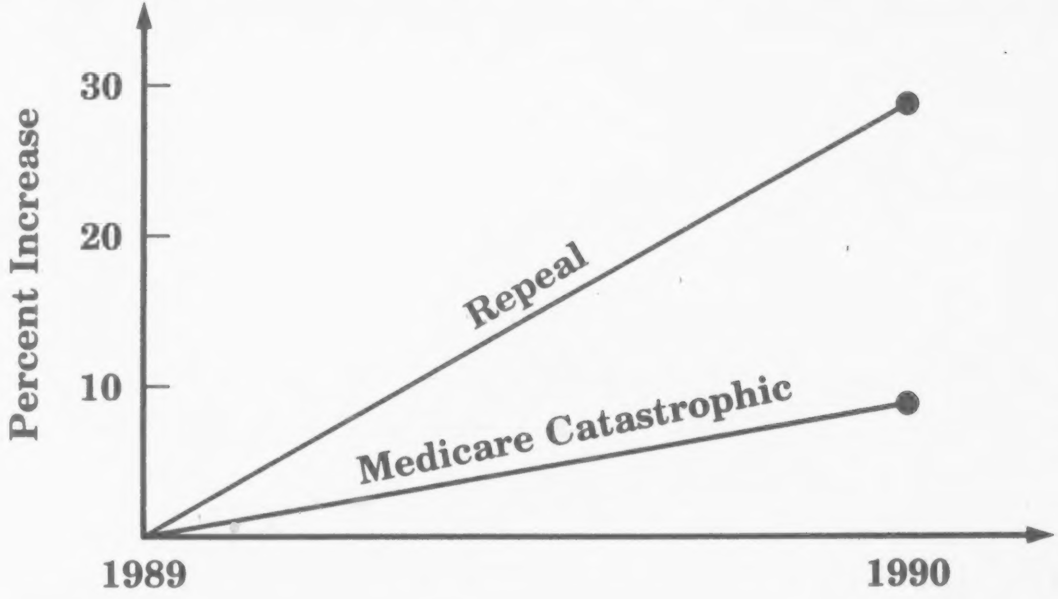
Attachment A

Typical Components of Medigap Cost Increases for 1990



Attachment B

Estimated Effects of Medicare Catastrophic Repeal on Medigap Rates



Source: BCBSA Survey, November 1989

PREPARED STATEMENT OF CONGRESSMAN RON WYDEN

Mr. Chairman, thank you for the opportunity to testify before you today. You have dedicated yourself to finding cures for the worst ills of our country's chaotic health care system, and I appreciate your vigor and vision.

The issue to be examined today, the regulation of Medigap, the term used to describe private health insurance policies sold to supplement Medicare, is certainly one of the most important economic issues facing the elderly today. Millions of seniors spend billions of dollars each year on Medigap policies and many are being ripped-off and cheated out of their limited, fixed incomes.

Seniors are being preyed on by agents who play to their fears that they'll be left with crushing health bills. Many of the policies pay out less in benefits than 50 cents for every premium dollar collected. Everyone in this room has older relatives and friends who have duplicate coverage, and it's not uncommon to find older people with a shoe-box full of policies.

What really makes me angry is that the Medigap insurance lobby knows that many consumers are being fleeced and they consistently inform policymakers to the contrary. For example:

John Matthews, senior counsel to the Health Insurance Association of America told the New York Times February 6, 1989, "Our research indicates that there is a large number of people with more than one policy, 30 to 40 percent. People have three, four, five, six, seven policies and it just doesn't make sense. There are a lot of people out there who don't know what's going on."

But the association's testimony submitted today says that there are only "occasional incidents of abuse." For the Medigap lobby to tell Congress that there are only occasional incidents of abuse is like saying that Joe Montana occasionally has a good game. This Medigap mess has flourished because Federal regulation is a voluntary, unenforceable patchwork of legal mumbo-jumbo—more loophole than law. Even if a state has its program certified as meeting minimum standards, there's no Federal requirement that Medigap companies that operate in the state meet those standards. Under the one Federal statute, 42 U.S.C. 1395ss, with criminal and civil penalties for exploiting seniors in the sale of Medigap policies there has not been a single prosecution because prosecutors find the Federal statute too vague to enforce.

A. DUPLICATION

I would like to examine the Federal statute in detail and make some recommendations. Under Section 1882(d)(3)(A) of the Social Security Act, the sale of duplicate Medigap policies is a felony. But there are at least four trap doors:

1. If an agent doesn't *ask* the beneficiary if she has other coverage, it's o.k. to sell that beneficiary an unlimited number of duplicative policies.
2. If the duplication is not "substantial," then multiple policies may be sold; but "substantial" is nowhere defined, rendering the statute completely unenforceable.
3. If the policies all pay out some benefits (no matter how insignificant in value), then they may be sold without limitation.
4. And, perhaps most shocking of all, agents may sell duplicative policies to the Medicaid population—the people who are least able to afford such waste.

This year, Congress must eliminate these four loopholes, and specifically bar duplicate coverage.

B. LOSS RATIOS

Current Federal law states that insurers may demonstrate to the states that their *expected* loss ratios will meet or exceed 60 percent for individual policies, and 75 percent for group policies.

Clearly these loss ratio "targets" are not being met. The General Accounting Office's most recent report on loss ratios confirmed that the *majority* (55 percent) of Medigap policies have loss ratios *below* the Baucus targets.

An internal memo from HHS Inspector General Kusserow dated February 10, 1987, sums up the loss ratio problem pretty well:

> "The fact remains that insurers are apparently making excessive profits. Even the 60 percent level appears excessive, considering that Medicare administrative costs run only 2 to 3 percent. This indicates that much of the insurers' remaining 40 cents of the premium dollar is profit."

If Congress truly believes that at least 60 cents out of every premium dollar paid for Medigap insurance should go towards paying for benefits, then it's time to make these loss ratios enforceable.

Requiring that Medigap insurers return 60 cents on the dollar—no excuses or "estimates" accepted—is a basic protection that beneficiaries deserve. "Normal" health insurance—the kind you and I have for our families—have loss ratios that average between 80 and 90 percent. The unacceptable truth is that some beneficiaries have a better chance of winning the Lotto than getting their monies'-worth out of their Medigap policy.

C. STANDARDIZATIONS

Current Federal law does nothing to facilitate true comparisons for purchasers of Medigap insurance. Although the National Association of Insurance Commissioners has established a "model standard" which states may voluntarily adopt, these standards allow insurers to offer unlimited variations in benefit packages.

The result is exactly what the senior counsel of the Health Insurance Association of America said in that great moment of candor: there is mass confusion. Walk into any senior center in the country and ask the seniors if they feel that the present regulatory system permits them to make understandable comparisons between various Medigap policies. Some states have found the problem so serious that they have developed counseling programs to help seniors weed through the tangle of complex terms and widely varying benefit packages.

Such counseling programs should be available to every beneficiary. I know that the Chairman of the Senate Aging Committee, Senator Pryor, is currently working on some legislation to encourage states to set up Medigap counseling programs. I commend his quick action to address the needs of the elderly and offer any assistance I can provide in support of his efforts.

But beyond counseling, there is one simple thing we can do: standardize Medigap benefits. The Medigap lobby will tell you that standardization stifles innovation. They will say that standardization takes away a senior's inalienable right to confusing legalese.

But virtually all of the consumer and senior organizations disagree. They think that standardization is a basic protection that will allow consumers to compare policies and prices on a level playing field.

As far as the industry's argument about "stifling innovation" is concerned, standardization doesn't limit choice, it *expands* consumer freedom by shifting the emphasis to competition on service and price instead of incomprehensible benefit packages. I am convinced that, if we would just give consumers the ability to make informed decisions in this market, many of our problems would disappear.

From coast to coast, seniors are having whopper premium increases—30, 40, and even 50 percent increases are not uncommon. Insurers have the right to make a reasonable profit, and the corresponding right to request premiums necessary to make a reasonable profit.

But I am concerned that the repeal of catastrophic has provided the perfect opportunity for some of the less respectable insurers to jack their rates through the stratosphere. A woman from the Select Aging Committee from the Maine state legislature recently called me to say that the Blues had requested up to a 47 percent increase.

Let's take a closer look at the 3 basic reasons insurers are giving us for their premium increases:

1. *General Health Inflation:* The MEI (Medical Economic Index) for 1989 was 8.5%. With many Medigap premium increases in the 40-50 percent range, this would mean that possibly 30 to 40 percent would have to be due to factors other than medical inflation.

2. *Catastrophic Repeal:* Only the Part A portion of the catastrophic law, which expanded hospital coverage to 365 days per year and skilled nursing facility coverage to 150 days per year, ever went into effect.

Industry representatives repeatedly argued that the catastrophic benefits accounted for only a tiny portion of their premiums. Health Care Financing Administration data shows that only about 2,000 Medicare beneficiaries, or .007 percent of all the elderly population, spend more than 150 days in the hospital. In addition, in June 1987, HIAA testified before the Energy and Commerce Health Subcommittee that a recent survey showed that "86 percent of policies covered unlimited hospital days, paying 100 percent of all Medicare allowable hospital expenses."

My question is: Since almost 90 percent of Medigap policies covered unlimited hospital stays already, and since the unlimited hospitalization and SNF expansion were the only benefits to ever take effect, what is it that insurers now have to pay for that they haven't been paying for all along?

3. *"Making for Previous Year's Losses."* It seems to me that this is the "catch all" that insurers use to justify any rate increase they want. After all, most of us can't calculate whether a specific percentage rate increase request is excessive when compared to previous year losses or not.

Since the industry is the only possible source for this kind of information, it shouldn't be surprising to us that this information is not available.

Maybe one of the reasons why Medigap premiums are going through the roof is that Medigap insurance is not adequately regulated. A November 1989 study of the House Select Committee on Aging revealed that two-thirds of the states do not require *any* approval before rate increases for group policies may go into effect. About one-third don't require rate approval for individual policies.

Mr. Chairman, I've been working to clean up the Medigap mess for more than 15 years, since my days as Co-Director of the Oregon Gray Panthers. There have been some reforms and there are good companies and good agents. But there still is much to do. Like writing a Federal statute that really protects seniors from Medigap abuses.

I plan to introduce my own comprehensive Medigap reform bill soon, and I hope that this hearing will spur similar legislative initiatives on this side of the Hill. I commend you, Senator Pryor, and Senator Kohl for your efforts, and I look forward to working with you on this important issue.